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UNCLAIMING AND REBLAMING: MEDICAID WORK REQUIREMENTS AND THE TRANSFORMATION OF HEALTH CARE ACCESS FOR THE WORKING POOR

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This Essay will look at the imposition of Medicaid work requirements in states that expanded access to Medicaid under the Affordable Care Act ("ACA" or "the Act").[1] Poverty policy scholars have roundly criticized this development, which began in 2018 after the Trump Administration indicated its interest in receiving proposals for new programs. This policy development underlines and links several long-standing themes: Access to affordable health care is a privilege rather than a right; the poor can and should be divided into deserving and undeserving categories; benefits provided to the poor need to be policed strictly to prevent fraud; and able-bodied adults should not be given any kind of support or benefit unless they are working for wages or actively seeking wage labor.

But of equal importance, and inextricably intertwined with the policy change, is the implementation of work requirements through the use of automated systems. This Essay will argue that understanding the shift to automation contributes to a stronger critique of work requirements. As an integral part of work requirements, automation reverses the conventional structural process of naming, blaming, and claiming while simultaneously creating injuries.[2] Automated systems remove human agents from decisionmaking, reconfiguring law's violence in ways that sublimate and mask state actors' intent by shattering it into numerous individual pieces that cannot be tied to cognizable wrongdoers.[3] Procedural due process becomes completely attenuated, utterly detached from what is happening to people. The victims of these failures, as the only visible agents remaining, are left to carry the blame, and breakdowns and problems become an anticipated and expected part of the process.

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1. Patient Protection and Affordable Care Act, 42 U.S.C. §§ 18001–18122 (2012).

2. *See* William L.F. Felstiner et al., *The Emergence and Transformation of Disputes: Naming, Blaming, Claiming . . .* , 15 L. & SOC'Y REV. 631, 631–654 (1980–81).

3. As Professor Robert Cover has explained, law is a form of state power and inherently incorporates violence. Administrative decisions as well as judicial decisions generate coercion and pain for their subjects. Robert M. Cover, *Violence and the Word*, 95 YALE L.J. 1601, 1601 (1986).

The stakes for grappling with these problems are high. Working poor adults are the canaries in the coal mine not just for policy failures, but for failures of justice. Compounding these failures stands to work continued injustice that carries down from generation to generation. And the failures will further pathologize poverty and those who must turn to Medicaid to address their medical needs.

This Essay will proceed by providing some background on the rise of automation to administer government benefit programs and then explain the adoption of the ACA and the shift in the types of waivers solicited by the Trump Administration, using Kentucky's story as an example. It then will analyze the implementation of waivers in Arkansas, detailing the problems Medicaid recipients and program administrators faced. The Essay then will address a series of lawsuits filed to challenge work requirements, noting that they have primarily focused on administrative interpretations of congressional intent. The Essay then will use the foregoing analysis to illustrate how the current framings of these challenges struggle to identify and acknowledge injuries wrought by automated systems. The Essay will close by suggesting that legal analysts develop new models to identify digital wrongs and enable corrective action.

A. A Little Background on Automation and Poverty

Since the early 1970s, both the federal government and the states have increasingly relied upon computers and metrics to contain public spending with respect to welfare.[4] Professor Virginia Eubanks describes the potent developmental process that produced the current environment. The public interest litigation and the activism of the National Welfare Rights Organization expanded welfare to incorporate black and brown recipients through the late 1960s and into the early 1970s. Opponents of Aid to Families with Dependent Children's ("AFDC")[5] expansion relied on racial stereotyping to revive stigma against the poor, incorporating claims of fraud and waste in a toxic brew.[6] In the wake of *Goldberg v. Kelly*[7] and other rulings from the late Warren Court emphasizing procedural due process, state actors sought neutral, nondiscretionary means of managing and distributing benefits, relying increasingly on automated systems. These systems, which Professor Eu-

4. VIRGINIA EUBANKS, AUTOMATING INEQUALITY: HOW HIGH-TECH TOOLS PROFILE, POLICE, AND PUNISH THE POOR 33 (2017).

5. 42 U.S.C. §§ 601–44 (1994). AFDC was the precursor to the current benefits system for poor families.

6. EUBANKS, *supra* note 4, at 32–33.

7. 397 U.S. 254 (1970).

banks characterizes as "digital poorhouse[s]," eliminated discretion but effectively shrank public spending "by increasing scrutiny and surveillance of welfare recipients."[8]

The shift from AFDC to Temporary Assistance for Needy Families ("TANF")[9] exacerbated these problems.[10] If AFDC was only precariously situated as an entitlement, TANF was designed to undercut any such expectations. The new system imposes lifetime eligibility limits and work requirements, restricts the use of benefits to support time spent pursuing higher education, and implements sanctions for noncompliance, including noncompliance with information-gathering initiatives.[11] Tracking, managing, and imposing these sanctions relies upon automated and algorithmic systems, facilitating and enhancing "moralistic and punitive poverty management strategies" while simultaneously removing individual agency and accountability for decisions.[12] The digital dream—"high-tech tools that promise to help more people, more humanely, while promoting efficiency, identifying fraud, and containing costs"—repeatedly transforms into a nightmare.[13] While the tools themselves may be new, as Professor Eubanks explains, they operate within a deeply rooted framework designed to discipline the poor and maintain distinctions between deserving and undeserving poor people.

Professor Eubanks' work shows the complete disregard for the real human consequences of sloppy technological design and rushed implementation in her discussion of automating welfare eligibility processes in Indiana.[14] In 2006, Indiana Governor Mitch Daniels aggressively promoted an overhaul of the state's welfare system to streamline the application process, identify and punish fraud, and privatize casework.[15] The State selected a private coalition of companies led by IBM to engineer the transformation.[16] Despite problems and failures in pilot programs, Indiana pressed forward with automation, producing horrific snarls of virtual paperwork and rampant errors. One Medicaid attorney in Bloomington estimated that ninety-five percent of applications submitted through the automated system produced eligibility errors.[17] Clients were denied and electronically removed from the system for

8. EUBANKS, *supra* note 4, at 33.

9. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105, 2110 (codified as amended primarily in scattered sections of titles 7 and 42 of the United States Code).

10. *See* EUBANKS, *supra* note 4, at 36–37.

11. *Id*. at 36.

12. *Id*. at 37.

13. *Id*. at 38.

14. *Id*. at 39–54.

15. *Id*. at 45.

16. *Id*. at 48.

17. *Id*. at 53.

failure to cooperate without being informed what specifically was wrong in their complicated applications for assistance. Caseworkers' jobs shifted radically from handling cases with which they were familiar to an entirely fragmented process that made them "slaves to the task system."[18]

B. Adoption of the Affordable Care Act and the Shift in the Waiver Program

The adoption of the ACA produced the greatest changes in the American health care and health insurance system since at least the 1960s. While most attention has focused on the debate over the ACA itself and Republican efforts to repeal it, the Act incorporates a great deal of room for quieter innovations that are taking place on the state level.[19] For instance, the Act created the Center for Medicare & Medicaid Innovation ("CMMI"), which encourages the development of "payment and delivery models that, ideally, will improve health outcomes while controlling costs."[20] States wishing to engage in reforms can seek funding to design and implement State Innovation Models ("SIMs") that state-level designers hope will be effective and applicable outside of the states that pilot them.[21] While national policymakers intended this shift to emphasize pragmatic, flexible, evidence-based experimentation, it has produced results heavily beholden to the political contexts and coalitions in states that have volunteered to participate.[22]

Other forms of flexibility and innovation under the ACA are even more problematic. Under Medicaid generally and prior to the passage of the ACA, Congress had put into place a waiver process to allow "experimental, pilot, or demonstration projects in welfare and Medicaid."[23] The waiver process, contained in section 1115 of the original legislation, began initially as a means of solving minor implementation wrinkles, but has grown steadily since then. By 2017, ten states were allocating three quarters or more of their Medicaid spending through programs for which they had obtained waivers.[24] Several of these waivers, adopted prior to the 2016 election, allowed states to expand their Medicaid coverage beyond the new flexibility provided under

18. *Id*. at 63.

19. Philip Rocco, Andrew S. Kelly & Ann C. Keller, *Politics at the Cutting Edge: Intergovernmental Policy Innovation in the Affordable Care Act*, 48 PUBLIUS: J. FEDERALISM 425, 426 (2018).

20. *Id*.

21. *Id*.

22. *See id.* at 448.

23. Carol S. Weissert & Matthew J. Uttermark, *Glass Half Full: Decentralization in Health Policy*, 49 ST. & LOC. GOV'T REV. 199, 207 (2017).

24. *Id*. at 208.

the ACA, providing assistance with health care premium payments. Others adopted incentives to reward healthy behavior.[25]

While these early ACA waivers reflected state-level political struggles, the Trump Administration additionally politicized the program by encouraging states to use section 1115 waivers for a new purpose. In 2017, Secretary of Health and Human Services ("HHS"), Tom Price, and the Administrator of the Centers for Medicare & Medicaid Services ("CMS"), Seema Verma, sent a formal letter to state governors "ushering in a new era for the federal and state Medicaid partnership where states have more freedom"—the freedom being permission to reconfigure Medicaid to require employment, impose premiums, penalize emergency room usage, and otherwise constrict coverage.[26] Several states responded eagerly, imposing work requirements, time limits, drug tests, required premiums, and other changes reflecting not only a desire to cut costs, but also to impose a particular vision of the state's responsibility to discipline the undeserving poor.[27]

Kentucky was one of the first states to submit a request for a waiver in response to this invitation and was the first to receive approval.[28] Kentucky had expanded Medicaid under the ACA and was widely trumpeted as a success story, having produced one of the largest drops in the rate of uninsured residents in the country, from sixteen percent in 2013 to eight percent in 2014.[29] This drop in the uninsured rate was accompanied by increased use of outpatient services and preventative care, "reductions in emergency room use, and improved self-reported health."[30] Despite these outcomes, Kentucky's new governor, Matt Bevin, elected late in 2015 after campaigning against the new system, moved forward to dismantle Kentucky's lauded state-based exchange and shift the state to the federal health care exchange.[31] The new Governor proposed drastically altering the earlier waiver that had expanded Medicaid coverage. He advocated for replacing it with a new waiver program, Kentucky Helping to Engage and Achieve Long Term

25. MARYBETH MUSUMECI & ROBIN RUDOWITZ, KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE ACA AND MEDICAID EXPANSION WAIVERS (2015), http://files.kff.org/attachment/issue-brief-the-aca-and-medicaid-expansion-waivers.

26. Weissert & Uttermark, *supra* note 23, at 208–09 (quoting Letter from Thomas E. Price, Sec'y, and Seema Verma, Ctrs. Medicare & Medicaid Servs. Adm'r, U.S. Dep't of Health & Human Servs., to all U.S. Governors, https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf).

27. *Id*. at 209.

28. Keahna Akins, Prospective Policy Analysis of the Kentucky HEALTH Demonstration Waiver 1, 10 (Nov. 5, 2018) (unpublished M.P.H. Capstone Project, University of Kentucky), https://uknowledge.uky.edu/cgi/viewcontent.cgi?article=1213&context=cph_etds.

29. *Id*. at 1.

30. *Id*. at 2.

31. *Id*.

Health ("Kentucky HEALTH") under section 1115. HHS approved the proposal in January 2018 with a scheduled implementation of July 1, 2018.[32]

Kentucky HEALTH fundamentally changed the earlier waiver program that had increased benefits under the ACA. For Kentuckians covered by Medicaid expansion, it eliminated dental and vision coverage and coverage for nonemergency transport, added an annual deductible, added an incentive account that rewarded enrollees for participating in "wellness" programs, disenrolled certain beneficiaries for delinquent payment of premiums, and required all "able-bodied" adults to participate in "work activities."[33] Two weeks after the waiver was approved, the National Health Law Program, the Kentucky Equal Justice Center, and the Southern Poverty Law Center collaborated in filing a class action lawsuit on behalf of sixteen Kentucky residents who would be affected by the new program, seeking to block both the implementation of the waiver program and any imposition of work requirements.[34]

The United States District Court for the District of Columbia relied on the Administrative Procedure Act[35] to find that the waiver granted to implement Kentucky HEALTH was inappropriate.[36] In the court's understanding, the new program failed because it did not promote the core objectives of Medicaid, a key threshold for any program requiring a waiver.[37] While the court embraced a deferential standard of review, it agreed with the plaintiffs that the central purpose of Medicaid is "to provide coverage and care to the most vulnerable" and, moreover, "to provide that care generally free of charge."[38] The court relied both on Medicaid's original authorization and the 2010 expansion under ACA to reach this conclusion, and found that the Secretary, in granting the waiver, had failed to ask two critical questions: Whether the new program "would cause recipients to *lose* coverage," and whether it would "help *promote* coverage."[39] In the court's comprehensive factual analysis, which relied on expert health policy amici, the new program would drastically slash the state's Medicaid rolls and "reduce health coverage for low-income individuals."[40] The court also mentioned that the new administrative system would likely "increase 'clerical and tracking errors and delays,' which in turn would 'cause inadvertent terminations.'"[41]

32. *Id*. at 3.

33. *Id*. at 4–5.

34. *Id*. at 5.

35. 5 U.S.C. §§ 551–706 (2018).

36. Stewart v. Azar, 313 F. Supp. 3d. 237, 272 (D.D.C. 2018) [hereinafter *Stewart I*] (referring to the waiver approval as "arbitrary and capricious").

37. *Id*. at 265.

38. *Id*. at 259–60.

39. *Id*. at 262.

40. *Id*.

41. *Id*. at 263.

The possibility of lost coverage by design or through the implementation of new delivery systems was critical to the court because, as the opinion emphasized, Congress's purpose in providing health insurance was not to promote health, but to make health care more affordable.[42] The court considered the meaning of expansion, finding that ACA's expansion of Medicaid to all individuals below prescribed income levels placed them on the same footing as previously covered vulnerable populations.[43] The Secretary of HHS's reliance on tangential factors—improving health outcomes, lowering costs, and fostering self-sufficiency—when determining if waiver was appropriate, supplanted focus on the primary goals of the program.[44] Thus, the court concluded the approval of the waiver was arbitrary and capricious.[45] The court, therefore, prevented the program from going into effect.[46]

This victory, significant as it was, had limits. Kentucky simply reapplied for the waiver. After receiving more than 11,500 comments, more than 8500 of which criticized the work requirement, CMMS again approved the waiver.[47] Kentucky set things in motion to implement the program on April 1, 2019, but the same plaintiffs filed suit again, alleging that the Secretary of HHS still failed to address the threat of mass loss of coverage.[48] To this claim, they further alleged that Kentucky's threat to end coverage for those who had obtained it through Medicaid expansion produced additional statutory concerns.[49] In the end, despite the additional round of consideration, the district court again found the program's approval by the Secretary was improper because the Secretary did not show that the new program "promotes the objectives of the Medicaid Act."[50]

While the Secretary agreed that the central purpose of Medicaid was to "furnish medical assistance to the populations covered by the Act," including those brought in under the ACA, he argued that the Medicaid Act had three additional objectives: advancing health and wellness, "increas[ing] beneficiaries' financial independence," and "ensur[ing] the fiscal sustainability" of

42. *Id*. at 267.

43. *Id*. at 269.

44. *Id*. at 272.

45. *Id*.

46. *Id*. at 274. The State of Kentucky, dissatisfied with the legal challenge, filed its own lawsuit against the *Stewart I* plaintiffs, claiming that enjoining Kentucky HEALTH constituted a legally cognizable injury because Kentucky would be forced to "un-expand" Medicaid. Bevin *ex rel.* Kentucky v. Stewart, No. 3:18-cv-00008-GFVT, 2018 U.S. Dist. LEXIS 140394, at *11 (E.D. Ky. Aug. 20, 2018).

47. Darla Carter, *Updated: Kentucky's Medicaid Overhaul Approved*, INSIDER LOUISVILLE (Nov. 20, 2018, 7:57 PM), https://insiderlouisville.com/health/kentuckys-medicaid-overhaul-approved/.

48. Stewart v. Azar, 366 F. Supp. 3d 125, 131 (D.D.C. 2019) [hereinafter *Stewart II*].

49. *Id*. at 136.

50. *Id*. at 137.

Medicaid generally.[51] The waiver, the Secretary claimed, was justified because the State had claimed that it advanced these objectives. The district court disagreed with this analysis. While the Secretary provided some analysis of the Act's core purpose of furnishing medical assistance, the court held that the Secretary had not adequately analyzed the coverage question. The real possibility, even under Kentucky's conservative estimate, that 95,000 individuals would lose access to coverage did not receive enough consideration.[52] The court likewise rejected the Secretary's contention that the promotion of health and financial self-sufficiency were purposes either of the legislation authorizing Medicaid or of the ACA.[53]

The State also defended the reapproval of the waiver based on Kentucky Governor Matt Bevin's reaction to the first lawsuit, *Stewart v. Azar*[54] ("*Stewart I*"). After the first waiver was invalidated, the Governor announced that if the Kentucky HEALTH program, with its mechanisms for reducing Medicaid use, did not go into effect, he would use his executive authority to roll back Kentucky's participation in Medicaid expansion.[55] The Secretary used this pronouncement to support his own original argument that financial sustainability for the State was a relevant consideration. If Kentucky opted to terminate expansion because of cost, the Secretary reasoned, Kentuckians would be worse off than if the demonstration waiver were approved, even though the waiver had cost-control provisions incorporated.[56] But the court rejected this line of reasoning, finding that a threat to de-expand Medicaid could not be used to circumvent the usual analysis of whether the government had appropriately taken into account the core purposes of Medicaid in approving or denying a waiver application.[57]

Since the Kentucky litigation began, HHS has approved section 1115 waivers for demonstration programs imposing work requirements in several other states. Five states—Arizona, Michigan, Ohio, Utah, and Wisconsin—have not yet implemented these programs.[58] Nineteen other states have applications pending.[59] Thus far, only Arkansas and Indiana have implemented their requirements, though, as discussed below, Arkansas's implementation

51. *Id*. at 139 (emphasis omitted).

52. *Id*. at 140.

53. *Id*. at 143–48.

54. 313 F. Supp. 3d 237 (D.D.C. 2018).

55. Darla Carter, *Oral Arguments Scheduled in Lawsuit Challenging Kentucky's Medicaid Overhaul*, INSIDER LOUISVILLE (Feb. 20, 2019, 1:00 PM), https://insiderlouisville.com/health/oral-arguments-scheduled-in-lawsuit-challenging-kentuckys-medicaid-overhaul/.

56. *See Stewart II*, 366 F. Supp. 3d at 140.

57. *Id*. at 154.

58. *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, KAISER FAMILY FOUND. (Oct. 9, 2019), https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/.

59. *Id*.

has been put on hold.[60] Indiana's work requirement went into effect in 2019, but the program does not require hours in the first six months.[61] Individuals receiving Medicaid in Indiana will have to demonstrate five hours per week beginning in months seven through nine of the program, with increases to follow.[62] Arkansas, however, put its work requirements into place, drawing intense national scrutiny—as well as criticism and more litigation, ultimately resulting in an injunction stalling implementation.[63]

C. Arkansas as a Digital Implementation Laboratory

A prospective analysis published by the Urban Institute in May 2018 gave a fairly clear picture of what to expect when the Arkansas waiver program, Arkansas Works, was implemented.[64] The Arkansas Works program required most able-bodied adults to work eighty hours per month or engage in other qualifying activities in order to be eligible for Medicaid coverage.[65] The Urban Institute's study used Arkansas's demographic information and survey data collected from Medicaid enrollees to identify anticipated problems for enrollees who would likely be subject to the work requirement but were not employed.[66] The study estimated an enrollment rate of approximately 269,000 non-disabled working age individuals in the state, with seventy-four percent likely to be exempt from work requirements, twelve percent subject to the requirements but already employed, and the remaining fifteen percent (approximately 39,000 people) potentially nonexempt but not working.[67]

Despite concerns about the new system, its phased rollout began on June 5, 2018.[68] The new system required significantly more information about Medicaid recipients than Arkansas had previously required to determine their appropriate categorization. The Arkansas Department of Human Services informed enrollees about upcoming changes, alerting them that "[s]ome people . . . have to participate in work activities to keep their health insurance coverage. Those people will have to report work activities to DHS. . . . DHS

60. *Id*.

61. *Id*. at n.5 ("While Indiana began implementation of the work requirement in 2019, no hours are required in the first [six] months.").

62. *Id*.

63. *Id*. at n.4.

64. ANUJ GANGOPADHYAYA ET AL., URBAN INST., MEDICAID WORK REQUIREMENTS IN ARKANSAS: WHO COULD BE AFFECTED, AND WHAT DO WE KNOW ABOUT THEM? (2018), https://www.urban.org/research/publication/medicaid-work-requirements-arkansas/view/full_report.

65. *Id*. at 5.

66. *Id*. at 7.

67. *Id*. at 3.

68. Louise Norris, *Arkansas and the ACA's Medicaid Expansion*, HEALTHINSURANCE.ORG (Oct. 14, 2019), https://www.healthinsurance.org/arkansas-medicaid.

decides if you have to report work activities. DHS needs some information from you to decide that."[69] New Medicaid applicants under the waiver system were required to answer a battery of questions designed to determine whether they fell into one of the exemption categories.[70]

The Urban Institute's pre-implementation study identified potential barriers to fulfilling the reporting requirements, including not having internet access in the household, not having access to a vehicle, having less than a high school education, and either having or living with "a household member with a serious health limitation."[71] Even the group likely to experience the least difficulty with the reporting requirements—those who were potentially nonexempt but holding down a job successfully—faced barriers, with fifty-four percent having at least one of these situations.[72] Of the individuals not employed but likely to be required to work, nearly a third had no internet access at home, and seventy-eight percent of them experienced one or more of the identified barriers.[73]

The Urban Institute had correctly predicted that nonexempt individuals who were not employed were likely to have difficulty "comply[ing] with the state's new work requirements, especially if the state does not make new investments in job training, job search assistance, employment supports, and related services (which cannot be financed by Medicaid)."[74] More ominously, even individuals exempt from the new requirements and those meeting them were likely to have problems, because they "have characteristics that may make it difficult for them to navigate the administrative processes established to enforce work requirements, thus putting them at risk of losing or failing to obtain Medicaid coverage even if [they are eligible] . . . possibly leading to coverage losses among people that the waiver is not intended to affect."[75] Of course, these projections would have been no surprise to anyone aware of Indiana's experience with automating welfare reform in 2006, discussed in the introduction to this essay.[76]

As in Indiana, neither concerns about the drastic nature of the changes proposed in Arkansas nor about the logistics of implementing automated reporting in Arkansas gave pause to implementation. Arkansas put Arkansas Works into place with the hope that it would prove an efficient and effective

69. GANGOPADHYAYA ET AL., *supra* note 64, at 4–5 (quoting DEP'T OF HUMAN SERVS., WHAT YOU NEED TO KNOW ABOUT THE WORK REQUIREMENT 1, http://news.arkansasbluecross.com/docs/librariesprovider4/default-document-library/program-flyer_aw.pdf?sfvrsn=5c076afd_0 (last accessed May 21, 2018)).

70. *Id*. at 9.

71. *Id*. at 4.

72. *Id*. at 18.

73. *Id*.

74. *Id*. at 23.

75. *Id*.

76. *See* notes 29–57 and accompanying text.

means of providing access to services for the deserving, cut costs, and reduce fraud. Advocates for the poor in Arkansas readily found nine plaintiffs to challenge the program, eight of whom were enrolled in Medicaid, and one of whom was disenrolled because he failed to comply with the work reporting requirements.[77]

The organized group of plaintiffs filed suit in November 2018. The suit noted the technical problems as one argument against the work requirement, but primarily challenged the Secretary's exercise of discretion in granting the waiver. While targeting Arkansas's program specifically, the broad frame of the suit alleged that the Trump Administration's invitation of waiver proposals seeks "to bypass the legislative process and act unilaterally to fundamentally transform Medicaid."[78] The plaintiffs characterized the implementation of the waiver program as "catastrophic," having stripped more than 8400 individuals of access to health care in just a few months and placing "thousands more" at risk.[79] While Arkansas had embraced Medicaid expansion under the ACA, the state had also initially requested a waiver at that time to impose a work requirement, which was denied by the administrative leadership of HHS during the Obama Administration.

The suit alleged that under the ACA, once a state has elected to expand Medicaid coverage, it may not treat enrollees differently, it is forbidden from imposing additional eligibility requirements, and it must ensure that all eligible people who apply for coverage "are served and get coverage."[80] Following the lead of the successful litigation in Kentucky, the suit challenged the granting of the waiver on the ground that the Secretary's authority to grant waivers only extends to states that will promote the objectives of the Medicaid Act (as amended by the ACA).[81] The lawsuit characterized the Secretary's solicitation of new proposals, the CMS Administrator's issuance of waivers, and the Arkansas government's characterization of the program's goals as a "fundamental[] transform[ation]" of Medicaid.[82] Transformation, however, is a legislative power, not one that the executive branch can exercise administratively under cover of executing the laws faithfully.[83] The plaintiffs argued that the purposes of Medicaid and the ACA—to ensure access to coverage—were completely subverted by the waiver program, which rendered coverage much more difficult to maintain for the expansion population.

77. First Amended Complaint for Declaratory and Injunctive Relief at 5–6, Gresham v. Azar, 363 F. Supp. 3d 165 (D.D.C. 2019) (No. 1:18-cv-01900-JEB), 2018 WL 8265789.

78. *Id*. at 2.

79. *Id*. at 3.

80. *Id*. at 10.

81. *Id*. at 12–13.

82. *Id*. at 2.

83. *Id*. at 29.

In the course of making the statutory and constitutional claims, the lawsuit alleged that the technological system developed to manage the waiver program was itself part of the problem because of its role in making access difficult. To contain costs, the work and community engagement requirement was limited to individual online reporting, even though the ACA required that individuals be permitted to submit information relating to eligibility in person, by telephone, or through the internet.[84] The system might best be described as cumbersome; at worst, it seemed intentionally designed to be obstructive. "To use the online portal, enrollees need[ed] an email address, a log-in and password unique to the portal, and a reference number provided in a multi-page letter sent by DHS. Enrollees use[d] the reference number to link their insurance account to the reporting portal."[85] Once the link between the enrollee's insurance account and the portal was established, it did not have to be reentered each month, but even after portal access was secured, enrollees had to navigate through multiple screens to report activities that establish compliance with the work requirements.[86] Furthermore, the portal, which was available only between 7:00 AM and 9:00 PM, was occasionally entirely inaccessible due to scheduled maintenance during these hours.[87] The stakes for failing to master the system were high. Failure to report work activities for a given month by the fifth date of the following month excluded any unreported activities from counting toward compliance.

Enrollees were also expected to navigate the online portal to claim exemption from the work requirement. Here, too, the stakes were high for errors. Periodic review of exemption attestations and compliance reports "may result in retroactive removal of months of exemption or compliance."[88] If these removals resulted in a finding that an enrollee had failed to comply for three months, the enrollee's insurance was canceled, and the case was referred for investigation for fraud and pursuit of repayment of benefits. Insurance cancellation also led to the exclusion of the cancelled individual from the system for an entire year, even if there was no finding of fraud.[89]

The plaintiffs all alleged experiences with navigating the system that ranged from frustrating to Kafkaesque. Take Adrian McGonigal, a forty-year-old resident of Pea Ridge, Arkansas, for example.[90] A Medicaid enrollee since 2014, diagnosed with chronic obstructive pulmonary disease ("COPD"), Mr. McGonigal received notice in June 2018 that the new work

84. *Id*. at 17, 20.
85. *Id*. at 20.
86. *Id*.
87. *Id*.
88. *Id*.
89. *Id*. at 19–21.
90. *Id*. at 33.

requirement would apply to him. He called DHS to report that he was employed at McDonald's but was informed that only online reports were accepted. Because he did not own a computer or smartphone, he had no ready access to the internet, and his lack of a driver's license left him dependent on public transportation to get to the nearest public library to complete the report. With assistance from his family, Mr. McGonigal was able to report his work hours in June 2018.[91] Relieved, he believed he had completed the requirement, and did not understand that he had to keep reporting.[92]

In August 2018, he also got a new job with Southwest Poultry.[93] He was initially assigned to work in the chicken processing department but found that the chemicals in his new work environment aggravated his COPD. The company moved him to the shipping department and his condition improved, enabling him to work between thirty and forty hours per week.[94] However, when he went to the pharmacy on October 5 to fill a prescription for his COPD, he discovered that his coverage had been terminated. Unable to pay the $800 cost, he left without his medication.[95]

Mr. McGonigal then entered into a round of frustrating communications to try to understand what had happened.[96] He called DHS, which referred him to his insurance company. In return, his insurance company referred him back to DHS. After securing representation from Legal Aid, he learned on October 19 that his coverage had been terminated for failure to report his work hours and he would not be eligible to resume coverage until the next calendar year.[97] Only when he protested that he had indeed reported his employment and cited the letter he had received in June acknowledging his report did he learn that his coverage had been canceled for failing to report his work hours *every month*. Ultimately, a DHS administrator granted him a good cause exemption on October 31, 2018, despite the fact that neither his lack of a permanent address nor his poor health, cited as reasons, were valid extenuating circumstances according to DHS policy.[98]

Unfortunately for Mr. McGonigal, while he was struggling to get his coverage restored, he could not afford the medications that controlled his COPD. After a trip to the emergency room, he missed several days of work, recovering at home because the hospital would not keep him as an uninsured patient. On October 22, citing his absenteeism, Southwest Poultry fired

91. *Id*. at 34.
92. *Id*. at 35.
93. *Id*. at 33.
94. *Id*.
95. *Id*. at 34.
96. *Id*. at 34–35.
97. *Id*. at 35.
98. *Id*.

him.[99] At the time of the filing, he was unemployed; the filing described him as "unsure how he will keep his coverage given that he no longer has a job and does not know how he will be able to meet the work or reporting requirements."[100]

Other plaintiffs had unique struggles with the waiver program, but common themes across their experiences were preexisting poor health, marginal work records that, for many, intertwined with their health struggles, and difficulty in understanding and using the electronic system for reporting work hours.[101] Of course, one can presume the plaintiffs were chosen as particularly poignant examples of the problems the waiver system created, and the organizations that selected them sought individuals who had tried to comply with the new requirements. Broader consideration of the program, however, suggests that their experiences were not unusual either in their efforts to comply with both the work and reporting requirements or in their inability to do so.[102]

The State's own records indicate that the program triggered significant coverage losses for noncompliance. The new rules implemented in June 2018 mandated termination from Medicaid after three months of not meeting the work and reporting requirements and enforced termination first against individuals between thirty and forty-nine years old.[103] At the end of August, the automated system flagged noncompliant individuals, and 4300 Arkansans became the first Americans to lose Medicaid coverage for failing to report sufficient work or work-related activities.[104] By the end of the year, more than 18,000 adults had lost coverage.[105] Of the clients who did not meet the work (or alternative) requirements in each month from June through December, almost all did so because they reported no work activities, suggesting significant barriers to successful navigation of the automated system.[106]

99. *Id*.

100. *Id*. at 36.

101. *See id.* at 30–48.

102. *See infra* notes 85–89 and accompanying text.

103. Joan Alker & Maggie Clark, *One Month into Medicaid Work Requirement in Arkansas, Warning Lights Are Already Flashing*, GEO. U. HEALTH POL'Y INST. CTR. FOR CHILD. & FAMILIES, (July 20, 2018), https://ccf.georgetown.edu/2018/07/20/one-month-into-arkansas-medicaid-work-requirement-the-warning-lights-are-already-flashing/.

104. Jennifer Wagner, *Over 4,300 Arkansas Beneficiaries Lost Medicaid This Month for Not Meeting Rigid Work Requirements*, CTR. ON BUDGET & POL'Y PRIORITIES: OFF THE CHARTS (Sept. 13, 2018, 4:45 PM), https://www.cbpp.org/blog/over-4300-arkansas-beneficiaries-lost-medicaid-this-month-for-not-meeting-rigid-work.

105. Joan Alker, *Arkansas' Medicaid Work Reporting Rules Lead to Staggering Health Coverage Losses*, GEO. U. HEALTH POLICY INST. CTR. FOR CHILD. & FAMILIES (Jan. 18, 2019), https://ccf.georgetown.edu/2019/01/18/arkansas-staggering-health-coverage-losses-should-serve-as-warning-to-other-states-considering-medicaid-work-reporting-requirement/.

106. ARK. DEP'T OF HUMAN SERVS., ARKANSAS WORKS PROGRAM 6 (Dec. 2018), https://humanservices.arkansas.gov/images/uploads/011519_AWReport.pdf.

A Kaiser Family Foundation analysis published in October 2018, which reported the initial alarming drop in Medicaid recipients in Arkansas, attributed the drop to the state's difficulties with informing people about the changes and managing the system, both of which implicate technology.[107] In discussing outreach efforts, the report presents a paradox, claiming that "[d]espite a robust outreach campaign conducted by the state, health plans, providers, and beneficiary advocates, many enrollees have not been successfully contacted."[108] The State relied primarily on telephone calls to relay information individually, but over half of enrollees did not have a telephone number listed in the state's database, many had incorrect listings, and many who were reached did not respond to the calls or voicemails.[109] The State partnered with a nonprofit organization, the Arkansas Foundation for Medical Care, to conduct outreach work, but the State's requirements for contact did not come close to covering all enrollees. For example, little effort was made to conduct outreach in any language other than English.[110]

As problematic as outreach was, the enrollment system was even more of a barrier. The anticipated problems with creating an online account, which required linking the online profile to a unique identifier number, materialized rapidly. The online reporting requirement, unique to Arkansas, demanded securing access through a fourteen-step process.[111] Users reported that the portal design was not mobile-friendly, though many enrollees only had internet access through their cell phones. To overcome the barriers created by lack of internet access and computer literacy, the waiver program allowed "registered reporters" to allow enrollees "to designate a third party to create their online accounts and access the portal to do their reporting."[112] Health plans and providers could designate staff to serve in this role, but few enrollees chose this option, and no funds were provided to educate either providers or enrollees about how to use the portal.[113]

The Kaiser Family Foundation analysis revealed that of the approximately 60,000 individuals who became subject to the new work requirements in August, more than 16,000 did not report the minimum required eighty

107. MARYBETH MUSUMECI ET AL., KAISER FAMILY FOUND., AN EARLY LOOK AT IMPLEMENTATION OF MEDICAID WORK REQUIREMENTS IN ARKANSAS 4 (Oct. 2018), http://files.kff.org/attachment/Issue-Brief-An-Early-Look-at-Implementation-of-Medicaid-Work-Requirements-in-Arkansas; *see also* Wagner, *supra* note 104.

108. MUSUMECI ET AL., *supra* note 107.

109. *Id*. at 4.

110. *Id*. at 5.

111. *Id*. at 6.

112. *Id*. at 8.

113. *Id*. Designating a registered reporter would also imply waiving one's privacy rights with regard to information subject to reporting.

hours of qualifying work activities.[114] The study could not definitively explain the reasons for these failures, but speculated that enrollees had difficulty creating and linking their accounts or reporting their work hours through the portal, concluding that "[n]on-compliance with the new requirements to date is attributed to lack of knowledge about the complex new requirements."[115]

The system did better in identifying enrollees who were exempt from the work reporting requirements, using data matching to verify that around two-thirds fell into one of the exempt categories. Enrollees not identified, though, had to report their justifications for exemption through the system. As the Kaiser Family Foundation analysis noted, the system required "[eleven] separate steps to report volunteer hours or to report an exemption based on pregnancy."[116] Here too, the complexity of the rules and the difficulty of navigating the portal took a significant toll. To add to the structural problems, technical problems cropped up, including a statewide computer outage on September 5, 2018, the deadline for reporting August hours, and the first deadline with the potential penalty of cancellation of benefits.[117] In addition to the system-wide failure:

> Internet and cell phone connectivity, especially in rural areas, can be slow and unreliable, which can translate to problems with reporting. One interviewee cited multiple examples of enrollees having difficulty linking their online accounts because the reference number provided in the notice did not work or they did not receive the notice with the reference number.[118]

For those not automatically identified as exempt, the system placed the burden on enrollees to determine their status, and the early experience of implementation revealed perplexing gaps. "Exemptions unlikely to be identified . . . include caring for an incapacitated person or experiencing a short-term incapacity, pregnancy, participation in an alcohol or drug treatment program, and full-time students."[119] The "medically frail" exemption was also particularly challenging for individuals with mental health needs, and individuals with disabilities by and large were not seeking accommodations.[120]

While the Kaiser Family Foundation analysis remarks that both research and interviews support the idea that promoting work for enrollees is valuable, it concludes that "the waiver design . . . tie[d] compliance to coverage, require[d] monthly online reporting and provide[d] no additional resources for

114. *Id.*
115. *Id.*
116. *Id.* at 10.
117. *Id.* at 11.
118. *Id.* at 12.
119. *Id.*
120. *Id.* at 9–10.

work supports," producing unintended and largely negative consequences.[121] Even as early as September 2018, researchers could see that the State had underestimated the complexity of implementing the changes, particularly the transition to an entirely online system, and had failed to provide adequate resources to manage either the transition or the operation of the new system. While technology facilitated tracking things like efforts to reach out to enrollees and potential enrollees, electronic outreach was ineffective for enrollees without stable addresses, phone numbers, or internet access.[122] These enrollees are by and large the most vulnerable and in need of assistance—and least likely to hear about the changes or be able to navigate them successfully.

Early evidence shows that enrollees were indeed losing access to coverage, but not because they were resisting work requirements. Rather, they were unable to navigate through the system effectively.[123] And while the expressed goal was to encourage new employment, the early data shows that most of the individuals meeting the work requirement were those who had already been holding down jobs successfully prior to the implementation of the waiver.[124] The automated withdrawal of coverage for individuals who failed to meet or stopped meeting the work requirements appeared to create coverage gaps that then generated uncompensated health care costs and worse health outcomes.[125]

But were these mere bumps in implementation? Even after the rollout, as noted above,[126] individuals continued to fail to report their qualifying activities, ultimately losing coverage. For each month of operation in 2018, far more people who did not meet the work reporting requirement reported no activities than those who reported some activities.

121. *Id.* at 18.
122. *Id.* at 19.
123. *See, e.g.*, *supra* notes 101–106 and accompanying text.
124. MUSUMECI ET AL., *supra* note 108, at 14.
125. *Id.*
126. *See, e.g.*, *supra* notes 114–120 and accompanying text.

TABLE 1. ARKANSAS MONTHLY REPORTING RESULTS 2018[127]

Reporting Period (2018)	Clients not Meeting Work Reporting Requirement	Clients Reporting No Activities	Clients Reporting Some Activities
June	7464	7392 (99.03%)	72
July	12,722	12,587 (98.94%)	135
August	16,357	16,132 (98.62%)	225
September	16,757	16,535 (98.68%)	222
October	12,128	11,966 (98.66%)	162
November	8426	8308 (98.60%)	118
December	4776	4703 (98.47%)	73

While Arkansas did not investigate the reasons for non-reports (individuals who reported no work activities), the rate of non-reporting did not pursue the downward trend that one might expect for beneficiaries learning to navigate a functional reporting system. Whatever the new system was encouraging, it did not appear to be substantially increasing the number of people who were managing to report some hours of work, even if not enough to fulfill the requirements.

On March 25, 2019, the Kaiser Family Foundation published an additional report. The researchers found that 18,164 individuals lost coverage during 2018, and only eleven percent had reapplied for and regained coverage by the time the study was completed in March 2019.[128] When the program began, only enrollees age thirty or older were subjected to the work requirement; as of January 2019, the requirement was expanded to include individuals between ages nineteen and twenty-nine.[129]

When enrollees lost coverage for not working, the sanction was generally imposed against enrollees who reported no work activities over the course of three months.[130] The failure to report any work at all suggests that many of these enrollees were unable to create accounts within the system or unable to navigate the reporting system with their accounts. The State, recognizing the large number of people removed by the automated system as a problem, made additional efforts to raise awareness about the policy changes, but the campaign could not penetrate into all of the communities with concentrations of potential enrollees.[131] The State did allow reporting hours by

127. ARK. DEP'T OF HUMAN SERVS., *supra* note 106, at 6.

128. ROBIN RUDOWITZ ET AL., KAISER FAMILY FOUND., FEBRUARY STATE DATA FOR MEDICAID WORK REQUIREMENTS IN ARKANSAS 1 (Mar. 2019), http://files.kff.org/attachment/State-Data-for-Medicaid-Work-Requirements-in-Arkansas.

129. *Id*.

130. *Id*. at 3.

131. *Id*. at 4–5.

phone, an option not available in the version of the program implemented in the late spring of 2018.[132] Despite these efforts, the report found that as the overall number of enrollees subject to the new work requirements increased by seventy-three percent from December 2018 to January 2019 (going from 60,680 to 105,158),[133] the State's data shows the percentage of enrollees reporting having satisfied the work requirement shrank.[134]

D. Early Federal Court Responses: Administrative Procedure and Congressional Intent

The Arkansas plaintiffs had some reason for optimism. As discussed in Section B, Kentucky's effort to implement similar requirements met a sharp rebuff at the district court level in *Stewart I* in 2018.[135] In March 2019, separate rulings invalidated work requirements again in Kentucky in *Stewart v. Azar* ("*Stewart II*"),[136] which had reapplied for its waiver after trying to cure the problems noted in *Stewart I*, and in Arkansas in *Gresham v. Azar*.[137] The same judge, Judge James Boasberg, elevated to the federal bench in 2011, wrote lengthy opinions in both cases;[138] he also considered and resolved in the same way a challenge to New Hampshire's program in *Philbrick v. Azar*.[139]

The ruling in the Kentucky case, which thwarted Kentucky's second attempt to implement its waiver, determined on technical grounds that Secretary Azar, in approving the waiver, had behaved in an arbitrary and capricious manner.[140] While HHS was permitted to consider a waiver program's positive impact on Medicaid's fiscal sustainability, the federal agency could not

132. *Id*.

133. *Id*. at 2.

134. ARK. DEP'T OF HUMAN SERVS., ARKANSAS WORKS PROGRAM 1 (Feb. 2019), https://humanservices.arkansas.gov/images/uploads/190315_February_AWReport.pdf. In December, of the 4776 Arkansans who did not meet the work requirement, 4703 reported no activities, and in January, these numbers increased respectively to 10,258 individuals who did not meet the requirements and 10,117 failing to report. *Id*. at 6. More individuals reported Supplemental Nutrition Assistance Program ("SNAP") compliance in January than in December, perhaps suggesting that some had transitioned to the piggyback reporting rather than duplicating their reporting through a more complicated system. *Id*. at 4.

135. *See supra* notes 36–46 and accompanying text.

136. 366 F. Supp. 3d 125 (D.D.C. 2019).

137. Gresham v. Azar, 363 F. Supp. 3d. 165 (D.D.C. 2019)

138. Andy Schneider, *Judge Blocks Arkansas and Kentucky Medicaid Work Requirement Waivers: What Does This Decision Mean for Other States?*, GEO. U. HEALTH POL'Y INST. CTR. FOR CHILD. & FAMILIES (Mar. 28, 2019), https://ccf.georgetown.edu/2019/03/28/judge-blocks-arkansas-and-kentucky-medicaid-work-requirement-waivers/.

139. No. 19-733, 2019 U.S. Dist. LEXIS 125675, at *1 (July 29, 2019).

140. Stewart I, 313 F. Supp. 3d 237, 272 (D.D.C. 2018).

lose sight of Medicaid's primary goal, which Judge Boasberg defined as "covering health *costs*."[141]

The Arkansas case worked in tandem with the Kentucky case. In Kentucky, the problem was one of federal administrative overreach that the State's efforts could not justify. Arkansas provided a further gloss on the problem by giving the court the opportunity to consider a different program with somewhat different justifications.

The implementation in Arkansas also afforded the court the opportunity to consider the program as it operated, but Judge Boasberg's analysis largely turned on how Secretary Azar had proceeded to approval.[142] One significant consideration about its operation was not substantive, but rather a question of standing. Arkansas denied that the plaintiffs had standing to challenge the online reporting system because it had "changed its policy before this suit so as to allow reporting by phone or in person."[143] The court determined that it did not have to grapple with this consideration because of the overall problems with the program, but Arkansas's raising of the issue suggested that this modification resolved a major implementation concern.[144]

Judge Boasberg noted the same problems that provoked his ruling against the Kentucky program. The Secretary, as he had with Kentucky's waiver, identified Medicaid's objectives as assisting in "improving health outcomes," addressing "behavioral and social factors" related to health outcomes, and incentivizing "beneficiaries to engage in their own health care," failing to acknowledge that the overarching purpose of Medicaid is to fund the provision of "medical services for the needy."[145] This purpose, Judge Boasberg explained, demanded that the Secretary conduct a far more searching analysis into claims by commentators that coverage losses would occur.[146]

What, then, was required? While not prescribing specifics, Judge Boasberg stated that, given the concrete and substantial warnings provided by expert commentators, "the agency must grapple with the risk of coverage loss."[147] The Secretary was not free to rely on Arkansas's failure to predict losses, as the Secretary had an independent obligation to explain the rationale for rejecting this concern.[148]

141. *Id*. at 266 (citing Waterkeeper All. v. EPA, 853 F.3d 527, 535 (D.C. Cir. 2017)).

142. *Gresham*, 363 F. Supp. 3d. at 175.

143. *Id*. at 174.

144. *Id*.

145. *Id*. at 176.

146. *Id*. at 177.

147. *Id*. at 178.

148. *Id*. The court further rejected the State's attempts to justify the Arkansas waiver program on the grounds that it served additional important purposes. *Id*. at 79.

The State nonetheless attempted to maintain the program on the grounds that interrupting it would be highly disruptive and confusing for program participants.[149] The court disagreed, ruling that even though Arkansas had already implemented its program, as with Kentucky, the appropriate solution was to vacate the waiver, terminating the program. The court did not, however, entirely close the door for Arkansas, conceding that the State and HHS could work together in the future to produce a program that would meet the appropriate administrative standards.[150]

New Hampshire's waiver program, called "Granite Advantage", which features even stricter work requirements than those implemented in Arkansas, was approved by the HHS Secretary in November 2018, and the State took the first steps toward implementation in early 2019.[151] New Hampshire's community engagement program, through which Medicaid recipients must meet their work requirement, launched in March 2019 and became mandatory in June 2019.[152] Advocates wasted no time, filing a class action suit on March 20 seeking an injunction against implementation of the program and the mandatory removals from Medicaid coverage slated to begin in August.[153] Like Arkansas, New Hampshire did not estimate how many individuals were likely to lose health coverage through its work requirement.[154]

The complaint against New Hampshire mirrors the successful strategy established in *Stewart I*. It leads with a discussion of the policy changes the waiver accomplishes and then discusses extensively statements by Trump Administration officials indicating an interest in thwarting the ACA and redefining the purpose of Medicaid by soliciting the new round of waiver requests.[155] The plaintiffs further highlighted the Trump Administration's commitment to promoting work requirements as a transformational component for Medicaid in the proposed 2020 budget, which estimates that implementation across several states will save "$130 billion over ten years."[156]

149. *Id*. at 183. The court retorted somewhat acidly that the federal government and Arkansas had expressed strong confidence in Arkansas's capacity to communicate the work requirement clearly to aid recipients. *Id*. at 184.

150. *Id*. at 183.

151. Louise Norris, *New Hampshire and the ACA's Medicaid Expansion*, HEALTHINSURANCE.ORG (Aug. 2, 2019), https://www.healthinsurance.org/new-hampshire-medicaid/.

152. *Granite Advantage Community Engagement Requirements Announced*, CONWAY DAILY SUN (Feb. 20, 2019), https://www.conwaydailysun.com/community/health/granite-advantage-community-engagement-requirements-announced/article_1e962caa-3527-11e9-b301-e3e4917e8cc6.html.

153. Complaint at 2, Philbrick v. Azar, 2019 U.S. Dist. LEXIS 125675 (D.D.C. July 29, 2019) (No. 1:19-cv-00773-JEB).

154. *Id*. at 20. New Hampshire also eliminated a previously established form of retroactive coverage, but likewise did not analyze the impact of this change. *Id*.

155. *Id*. at 25.

156. *Id*. at 31.

The New Hampshire plaintiffs articulated a different set of reasons than the Arkansas plaintiffs for struggling with the work requirements. New Hampshire's enrollees faced challenges not as much because of technical problems but rather because of the substantive difficulties in their lives and what counts and does not count as work.[157] One New Hampshire plaintiff, Mrs. VLK, alleged that the reporting requirements would create problems for her, citing challenges in completing forms and acquiring and uploading documentation, but these allegations do not discuss technology or automated termination as a distinctive problem.[158]

Judge Boasberg again considered the arguments, describing the issues in the case as "all too familiar."[159] He noted that New Hampshire's work requirements mandated more monthly hours of work than enjoined programs in Kentucky and Arkansas, and the New Hampshire program required work from a broader age category than Arkansas Works.[160] The Secretary's consideration of New Hampshire's waiver failed to consider the ill effects of implementation in Arkansas, and the agency's responses to concerns were "identical" to those the Court had rejected in its evaluation of Kentucky's program.[161] Despite the introductory discussion framing the dispute as largely following the path of prior litigation, Judge Boasberg analyzed the program and its justifications to support his conclusion that Secretary Azar's approval of Granite Advantage was arbitrary and capricious.[162] The Secretary relied largely on New Hampshire's statements about its intention to support the Medicaid provision rather than grappling with the copious expert evidence predicting coverage losses. As Judge Boasberg noted, "Similar intentions existed and corresponding protections were put in place in Kentucky, but the Commonwealth projected a coverage loss equivalent to 95,000 people losing Medicaid for one year. Same with Arkansas, yet it found that nearly 17,000 lost coverage at some point in the first six months alone."[163]

Neither the findings of negative outcomes nor the lawsuits have deterred other states, however. By March 2019, the Secretary had approved work requirement waiver requests in Indiana, Wisconsin, Michigan, Maine, Arizona, Ohio, and Utah in addition to the waivers discussed above.[164] Alabama,

157. *Id*. at 34.

158. *Id*. at 40.

159. *Philbrick*, 2019 U.S. Dist. LEXIS 125675, at *3.

160. *Id*.

161. *Id*. at *4.

162. *Id*. at *22.

163. *Id*. at *29.

164. Complaint, *supra* note 153, at 29. While Maine's waiver was approved in late 2018, when Maine's newly elected governor took office in 2019, she "informed CMS that the state would not accept the terms of the waiver and would instead direct state officials to make vocational training and workforce supports available to enrollees." *Id.*

Mississippi, Oklahoma, South Carolina, South Dakota, Tennessee, and Virginia have applications pending with HHS.[165] West Virginia's legislature also took the first steps to add West Virginia to the list.[166] The court battle over waivers will continue; Judge Boasberg's narrow rulings leave room for further reconfiguring of extant programs to try to nudge them toward legal acceptability, and the states moving forward are likely to attend to this advice.

Recognizing the disruptive nature of this conflict, the United States Court of Appeals for the District of Columbia Circuit granted the Trump Administration's request for an expedited appeal of both *Gresham* and *Stewart II*. The litigation should result in a ruling by the end of 2019.[167] That ruling will likely identify the core question of whether the Trump Administration's advocacy for and approval of programs implementing work requirements violates the Administrative Procedure Act, perhaps with some broader questioning of what constitutes an illegitimate administrative change to a statutory purpose. Legal commentators will watch these cases closely to see if they might provoke Supreme Court interest down the road, as they raise important questions about administrative law, particularly administrations' capacity to reconfigure legislative and previous administrative purposes.

As the litigation evolves and increasingly focuses on these questions, however, it evades another important set of questions about what constitutes injury and how injury can be identified. The plaintiffs in the cases lodge their claims of injury against the administrative approval of these programs but do so by objecting to the administrative understanding of the purposes of Medicaid. This set of claims, while important, obscures another type of injury lodged in the programs themselves, addressed in the Section E.

E. Digital Management and Digital Injury

As the analysis above illustrates, the claims against Medicaid work requirements are intertwined with implementation problems (or prospective concerns about what will happen when work requirements go into effect). At first blush, these problems appear simply as a side effect of the reporting requirements themselves. Work requirements demand some form of verification, of course, and opponents of work requirements would argue that even

165. *A Snapshot of State Proposals to Implement Medicaid Work Requirements Nationwide*, NAT'L ACAD. ST. HEALTH POL'Y, https://nashp.org/state-proposals-for-medicaid-work-and-community-engagement-requirements/ (last updated Oct. 21, 2019).

166. Simon F. Haeder & Philip Rocco, *Terrible Idea: Adding More Bureaucracy to Medicaid Program*, REG.-HERALD (Feb. 22, 2019), https://www.register-herald.com/opinion/columns/terrible-idea-adding-more-bureaucracy-to-medicaid-program/article_b1cb24e4-fd1a-55e6-bdb9-034dfb92f9cd.html.

167. Sara Rosenbaum, *An Expedited Appeal for the 1115 Medicaid Work Experiment Cases*, HEALTH AFF. BLOG (Apr. 26, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190425.862133/full/.

if the system itself were relatively easy to navigate and did not create problems based on a perceived digital divide, the demand that people work itself undermines the core purposes of Medicaid. As waiver programs have moved forward, states have clearly been attending to HHS's failure to defend Arkansas Works in court and the potential for such challenges. Maine's work requirement, while demanding more hours from Medicaid enrollees than Arkansas Works, gives them a variety of options for fulfilling the reporting requirement rather than insisting that it happen entirely online.[168] In Michigan, while the primary means of administering the work requirement will be through self-reporting via an online portal, the State has also developed an expanded call center with automated reporting capability.[169] Other states, as indicated in Table 2, have followed suit. But all rely on a reporting system that penalizes enrollees for failing to log their hours through the designated means. Furthermore, all provide mechanisms for automatic disenrollment of individuals who do not meet the reporting requirements.[170]

168. *Granite Advantage*, *supra* note 152.

169. MANATT, PHELPS, & PHILLIPS, LLP, POTENTIAL ENROLLMENT IMPACTS OF MICHIGAN'S MEDICAID WORK REQUIREMENT 2 (2019), https://www.manatt.com/Manatt/media/Media/Images/White%20Papers/Manatt_MI-Work-Req-Estimates_20190206-Final.pdf.

170. *A Snapshot of State Proposals*, *supra* note 165.

TABLE 2. APPROVED WAIVERS WITH WORK REQUIREMENTS

State	Date of Implementation	Work Requirement	Lockout Provision	Reporting	Status
Ky.[171]	4/1/2019	80 hours/month	If annual eligibility not established, locked out for 6 months.	Online, by phone, or in person	Enjoined
Ark.[172]	6/5/2018	80 hours/month	If noncompliant for 3 months, locked out for remainder of calendar year.	Online, by phone, or in person (added after implementation)	Enjoined
N.H.[173]	6/1/2019	100 hours/month	If noncompliant for 1 month, locked out until hours are completed.	Online, by phone, by mail, or in person	Enjoined
Ind.[174]	Jan. 2019	1-6 months: no requirement 7-9 months: 5 hours/week 10-12 months: 10 hours/week 13-18 months: 15 hours/week 18+ months: 20 hours/week	If noncompliant for 1 month, locked out for 3 months.	Online, by phone, by mail, or in person	No litigation pending

171. MaryBeth Musumeci et al., *Re-Approval of Kentucky Medicaid Demonstration Waiver*, KAISER FAM. FOUND. (Nov. 29, 2018), https://www.kff.org/report-section/re-approval-of-kentucky-medicaid-demonstration-waiver-table/.

172. Norris, *supra* note 68; *see also* Gresham v. Azar, 365 F. Supp. 3d 165 (D.D.C. 2019).

173. *A Snapshot of State Proposals*, *supra* note 165; *Granite Advantage*, *supra* note 152.

174. MARYBETH MUSUMECI ET AL., KAISER FAMILY FOUND., APPROVED CHANGES IN INDIANA'S SECTION 1115 MEDICAID WAIVER EXTENSION (Feb. 2018), http://files.kff.org/attachment/Issue-Brief-Approved-Changes-in-Indianas-Section-1115-Medicaid-Waiver-Extension; *A Snapshot of State Proposals*, *supra* note 165.

Wis.[175]	Fall 2019	80 hours/month 48-month nonconsecutive time limit	If still on the program after 48 months, locked out for 6 months.	Not yet promulgated	No litigation pending
Mich.[176]	1/1/2020	80 hours/month	If noncompliant for 3 months in any 12-month period, locked out until compliant for at least 1 month.	Not yet promulgated	Ques-tioned by new governor
Me.[177]	Implementa-tion Cancelled	20 hours/week	If noncompliant for more than 3 months in a 36-month period, locked out.	NA	With-drawn by new governor
Ariz.[178]	1/1/2020	80 hours/month	If noncompliant for 1 month, locked out for 2 months.	Online, by phone, or in person	No litigation pending

The arguments plaintiffs have raised in the pending lawsuits tie back to the questions of administrative discretion and how far administrative agencies can go in reinterpreting statutory purposes as they devise new rules for implementing statutes. The injury is a procedural and democratic injury to the American people stemming from administrative failure to respect the will of the Congresses that passed the authorizing legislation defining the proper purposes of Medicaid. Secondary harm occurs to state taxpayers, who suffer from the state's own unwillingness to acknowledge and grapple with expert witnesses who predict harm from these policies. The tertiary harm affects

175. Riley Vetterkind, *State Will Implement Medicaid Work Requirements Until Told Otherwise*, WIS. ST. J. (Mar. 30, 2019), https://madison.com/wsj/news/local/govt-and-politics/state-will-implement-medicaid-work-requirements-until-told-otherwise/article_2201e541-9a8b-5626-8f0e-f4f732bd0987.html; *A Snapshot of State Proposals*, *supra* note 165.

176. MANATT, PHELPS, & PHILLIPS, LLP, *supra* note 169, at 2.

177. MARYBETH MUSUMECI ET AL., KAISER FAMILY FOUND., PROPOSED MEDICAID SECTION 1115 WAIVERS IN MAINE AND WISCONSIN (Aug. 2017), http://files.kff.org/attachment/Issue-Brief-Proposed-Medicaid-Section-1115-Waivers-in-Maine-and-Wisconsin; Michael Shepherd, *Mills Reverses LePage Push for Medicaid Work Requirements*, BANGOR DAILY NEWS (Jan. 22, 2019, 6:13 PM), https://bangordailynews.com/2019/01/22/politics/mills-reverses-lepage-push-for-medicaid-work-requirements/.

178. Harris Meyer, *CMS Approves Arizona's Tough Medicaid Work Requirement*, MOD. HEALTHCARE (Jan. 18, 2019, 12:00 AM), https://www.modernhealthcare.com/article/20190118/NEWS/190119901/cms-approves-arizona-s-tough-medicaid-work-requirement.

the plaintiffs themselves who have lost access to their benefits, but their injury is contingent upon the idea of administrative wrongdoing. One gets the sense in reading the complaints and opinions that if Congress were to pass legislation declaring that shifting people from welfare to work was part of Medicaid's core purpose, the challenges to work requirements, no matter how strict or how they were designed for implementation, would evaporate.

The story of Medicaid work requirements, however, ties in with other implementation efforts relying on automated systems. Putting work requirements in this context raises a different set of questions about how entitlement to government benefits should work and, to put it in simple terms, the amount of aggravation, delay, frustration, and error we can rightfully expect people to endure to gain access to statutorily granted benefits. Herein lurks an interesting equality problem, one that pushes us to question more deeply how democratic checks can function in an increasingly automated world. It also presses us to look more closely at the relationship between equality and intent. We need to think more comprehensively about how disparities function and the extent to which reliance on automated systems shunts off claims of wrongs or injury into a corral of mere inconvenience.

Such thinking, while not systematic, is already happening among some officials. Michigan Governor, Democrat Gretchen Whitmer, was inaugurated after CMS had approved a section 1115 waiver for Michigan to implement a work requirement program. In her formal letter acknowledging the waiver and the responsibilities it imposed, she cited Arkansas's experience of mass coverage losses and noted "Michigan's statute is more sweeping than Arkansas's waiver, threatening a broader range of adults with more exacting reporting demands."[179] She declared her intent to work with the legislature to adjust the program to improve its ability to "preserve coverage, promote work, and reduce red tape for Michiganders, while also minimizing administrative cost to the state."[180] While she did not go so far as to point the finger at automation itself as a problem, she recognized the damage strict reporting requirements and automated terminations can cause in an environment in which some of the most precariously poised individuals in a state are thus burdened and surveilled.

Is automation actually a new problem? Professor Virginia Eubanks argues—and I mostly agree with her—that it is not.[181] Rather, it provides a new means of continuing long-established practices of distinguishing between the deserving and undeserving poor in ways that often result in racially disparate outcomes. While algorithms themselves operate in a supposedly

179. Letter from Gretchen Whitmer, Governor of Mich., to Seema Verma, Adm'r., Ctrs. for Medicare & Medicaid Servs., (Feb. 8, 2019), https://www.michigan.gov/documents/whitmer/Letter_from_Gov._Whitmer_to_CMS__645767_7.pdf.

180. *Id*.

181. *See* EUBANKS, *supra* note 4.

arm's-length fashion, they cannot remove human judgment and human bias. They merely conceal it. As Professors Danielle Citron and Frank Pasquale note, "Because human beings program predictive algorithms, their biases and values are embedded into the software's instructions . . . . Scoring systems mine datasets containing inaccurate and biased information provided by people."[182]

Automation does, however, raise some significant new issues, particularly with regard to vulnerable populations, which the experience of Medicaid work requirements illustrates well. And as Professor Eubanks notes, even if a basic sense of justice and fairness do not move policymakers to recognize these issues with respect to the management and surveillance of the poor, self-interest should come into play at some point.[183] It may become difficult to draw bright lines around the kinds of problems that are increasingly becoming routine for the poor, as anyone who has been through a struggle over automated denials of health insurance claims can readily attest.

It's tempting to look at automated systems like the work reporting system implemented in Arkansas and pinpoint the problem as one of faulty technology. But even if the system itself had been designed to be more user friendly, had not experienced glitches, and had been highly accessible to its users, it raises serious concerns about how we as a society understand and manage access to health care for the poor. The eager embrace of these systems underlines the collapse of the logic that drove the Supreme Court's demand for procedural fairness in *Goldberg v. Kelly*, presses the idea of access to health care as a benefit to be obtained in exchange for work, removes identifiable agents from the entire process of creating injuries, and reframes the beneficiaries of state-funded health insurance as the taxpayers who (very loosely) subsidize it, rather than the actual recipients.[184]

Goldberg v. Kelly addressed welfare, not health insurance benefits, but the 1970 ruling brought the Supreme Court close to understanding public benefits as a form of property. Justice Brennan's opinion for the Court ruled that prior to terminating public assistance benefits, states were obligated to provide evidentiary hearings to recipients.[185] Because the benefits were a statutory entitlement, the Fourteenth Amendment's procedural due process required more than a cursory examination before benefits were withdrawn. The Court emphasized that form as well as function mattered.[186] Denying that written appeals were sufficient, the Court explained:

182. Danielle Keats Citron & Frank Pasquale, *The Scored Society: Due Process for Automated Predictions*, 89 WASH. L. REV. 1, 4 (2014).

183. EUBANKS, *supra* note 4.

184. 397 U.S. 254, 255 (1970).

185. *Id*.

186. *Id*. at 266–67.

> Written submissions are an unrealistic option for most recipients, who lack the educational attainment necessary to write effectively and who cannot obtain professional assistance. Moreover, written submissions do not afford the flexibility of oral presentations; they do not permit the recipient to mold his argument to the issues the decision maker appears to regard as important. Particularly where credibility and veracity are at issue, as they must be in many termination proceedings, written submissions are a wholly unsatisfactory basis for decision.[187]

The opinion further emphasized the need for confrontation and cross-examination of adverse witnesses as hallmarks of due process.[188] In its reasoning, the Court was clear that terminations without review or consideration constituted wrongful behavior rising to the level of a legal injury for which the state had to proffer a means of redress.

Fundamentally, the Court posited that some kind of deliberative consideration was needed. Individuals receiving public benefits were to be given the opportunity to discuss face-to-face the human circumstances of their case, to question and persuade, and to inject their individual perspectives into the machinery of consideration and denial.[189] Scholars, most notably Professor Lucie White, have shown that the deliberative vision articulated in the Court's opinion did not materialize from the ruling.[190] Nonetheless, public benefit recipients learned to work within the system, often with the help of sympathetic caseworkers who could reformulate their messy narratives into claims that circumvented or short-circuited problematic results.[191]

Goldberg v. Kelly, as applied to welfare, was undercut when Congress transformed the AFDC program to TANF, diminishing the limited property-like aspects of benefits by making them temporally limited and more contingent on work or other "productive" activities, but a sense remained that recipients of public benefits had some vested interest in what they were receiving.[192] Even under TANF, individual caseworkers handled cases and managed their administration, functioning to a limited extent as street-level bureaucrats, for all the good and ill that this model brings. With regard to Medicaid, another major government benefit program for the poor, two forces have converged—the more general push toward modernization, including automation, and the move toward work requirements.

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187. *Id*. at 269.

188. *Id*.

189. *See id.* at 267–70.

190. Lucie E. White, *Subordination, Rhetorical Survival Skills, and Sunday Shoes: Notes on the Hearing of Mrs. G.*, 38 BUFF. L. REV. 1, 3 n.6 (1990); *see also* Julie A. Nice, *Forty Years of Welfare Policy Experimentation: No Acres, No Mule, No Politics, No Rights*, 4 NW. J.L. & SOC. POL'Y 1 (2009).

191. White, *supra* note 190.

192. *See* Nice, *supra* note 190, at 1–2.

Modernization, as Professor Eubanks and other scholars note, has taken place generally in benefits administration. The targets for automation include "eligibility determination and case management systems; Web-based systems for submitting applications, reporting changes, and finding case status and notices; call centers . . . for reporting changes, giving case status information, and conducting eligibility interviews; digitized document imaging; and business process reengineering."[193] Part of this transformation includes moving from a case worker-centered model "toward a model in which workers perform designated functions."[194] And the ACA specifically encouraged automation: "Enhanced federal funding (i.e., 90 percent) is available for state Medicaid information technology (IT) upgrades to accomplish the streamlining and data sharing requirements."[195]

The new solicitation for work requirement programs has enhanced emphasis on monitoring and reporting through electronic systems. On March 14, 2019, CMS released new guidance to states employing section 1115 demonstration programs mandating "regular reporting on key monitoring metrics upon implementation" and requiring states to "partner[] with an independent evaluator."[196] While the precise variables and collection methods are not specified, the reporting requirements create greater incentives for automating data collection and reporting and measure success based on the state's own descriptions of its objectives. As a blog post anticipating this development explained, states running programs were encouraged to think about data availability and quality in their program designs: "Where will the data to perform the evaluation come from? Does the data structure allow for the analyses proposed in the evaluation?"[197] These new reporting protocols do not contemplate requiring any direct connection to the central objective of providing access to health coverage.

Lost in this push for automation and data collection is recognition of the problems, both in the initial implementation and in the long run. With respect

193. Gina Mannix et al., *How to Protect Clients Receiving Public Benefits When Modernized Systems Fail: Apply Traditional Due Process in New Contexts*, CLEARINGHOUSE ARTICLE, Jan. 2016, at 1, https://nclej.org/wp-content/uploads/2016/01/ClearinghouseCommunity_Mannixetal-Published-Article-with-Copyright.pdf.

194. *Id*.

195. *Id*. at 1 n.2.

196. Press Release, Ctrs. for Medicare and Medicaid Servs., CMS Strengthens Monitoring and Evaluation Expectations for Medicaid 1115 Demonstrations (Mar. 14, 2019), https://www.cms.gov/newsroom/press-releases/cms-strengthens-monitoring-and-evaluation-expectations-medicaid-1115-demonstrations.

197. Kristin Allen, *CMS Section 1115 Medicaid Demonstration Evaluation Requirements: Implications for Designing Consumerism & Personal Responsibility Waivers*, HEALTH MGMT. ASSOCIATES BLOG (Oct. 18, 2018), https://www.healthmanagement.com/blog/cms-section-1115-medicaid-demonstration-evaluation-requirements-implications-designing-consumerism-personal-responsibility-waivers/.

to implementation, chaos and failure have quickly become expected outcomes in shifts to automated systems. The states proposing and adopting work requirements know that Medicaid recipients will struggle with reporting under the new systems. They know, or should know, that the systems will fail.[198] They recognize that individuals grappling to implement and work with the systems will struggle and fail to make them produce appropriate outcomes. Judge Boasberg's rulings take seriously the claim that demonstration programs did not consider the potential for large numbers of recipients to lose access to coverage. He nonetheless frames this problem simply as one of administrative mismatch with the purposes of Medicaid.

Further, both the states proposing these programs and CMS officials know that once fully implemented and running as intended, the systems will make discretion almost impossible to exercise. Adoption of automation serves many purposes, including improving efficiency, linking information, and preventing fraud, and these purposes play major roles in the wave of new waiver approvals. But in serving these purposes, automation transforms the programs themselves and the broader interests they supposedly serve. Systems designed for fraud prevention, cost savings, and the removal of human judgment prioritize these interests to the point that they overshadow the Medicaid program's aim to provide assistance to meet health care costs. Indeed, as noted in Table 2, the systems are designed to lock people out for a variety of periods ranging from months to a lifetime, based simply on the automated determination of prior eligibility and access and failure to report the required number of work hours for the designated period.

The problem thus runs deeper than criticizing the unwieldy nature of the systems themselves, the mistakes they make, or the difficulty that the target population has in using them, because these outcomes have no identifiable agents-as-wrongdoers other than the enrollees. The problem then becomes the enrollees themselves. Efforts, as witnessed by policy changes and litigation, focus on "fixing" the enrollees by doing more outreach, trying to educate them better about their responsibilities, and, albeit apathetically, providing more assistance to them in navigating the digital terrain. Still, when resources are not forthcoming, the diagnosis comes down to their failure to meet the requirements, even if empathetic state agents recognize how difficult or impossible it is for them to do so.

Because automation removes agency, it becomes much harder to identify injuries and wrongs to enrollees in legally cognizable terms. In Indiana's failed experiment with automation, after a lengthy and ugly court battle over whether the State or IBM was responsible for failure, Indiana's Court of Appeals affirmed the trial court's ruling holding IBM responsible to the tune of

198. *See* Philbrick v. Azar, Civ. No. 19-773 (JEB), 2019 U.S. Dist. LEXIS 125675, at * 22–29 (July 29, 2019).

$78 million. One of the attorneys representing the State, however, characterized the win as "a significant victory for Hoosier taxpayers."[199] This comment, which echoed the trial judge's lament situating Indiana taxpayers as the victims of the automation failure, underlines the invisibility of enrollees as individuals with rights that have been violated.

There is no simple answer—automation is ubiquitous and will not be abandoned. We should, however, move away from understandings of legal wrongs that require identifying individual malfeasors who intend to do harm, or at least have been negligent, in these kinds of situations. It may be difficult to point an accusatory finger at an algorithm, but an automated denial of benefits or a complicated digital system's blocking access to health care can lead to bad outcomes that should be understood as legal injuries. Scholars, policymakers, and the public need to reformulate our thinking to develop frameworks moving to blaming and ultimately claiming state responsibility. The first step, though, is to stop ignoring the real and consequential injuries that Medicaid work requirements are creating. The harm is not just the damage produced to institutions like Medicaid by an administration eager to undo the will of Congress by approving policies that undermine legislation. It is more urgently to enrollees who find themselves held accountable for the algorithmic damages that cheapen and threaten their very lives.

199. Associated Press, *Appeals Court Affirms Ruling that IBM Owes Indiana $78 Million*, INDIANAPOLIS BUS. J. (Sept. 28, 2018), https://www.ibj.com/articles/70690-appeals-court-affirms-ruling-that-ibm-owes-indiana-78-million.