

Medicaid Waivers, Administrative Authority, and the Shadow of Malingering

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Abstract: From 2018 through 2020, HHS approved state Medicaid demonstration waivers to impose new eligibility conditions such as work requirements, connecting current “personal responsibility” rhetoric and historical suspicion of malingering. The Biden administration reversed course but advocated to the Supreme Court for expansive administrative discretion. This approach supports health equity now but could enable reemergence of restrictive health policies down the road.

On the last day of his presidency, the Trump administration filed a brief in the U.S. Supreme Court defending the legality of work requirements in the Medicaid program. Such requirements deprive the poorest Americans of access to care and are rooted in a long history of discriminating against individuals deemed undeserving of government assistance. The concept of deservingness reflects fear of “malingering,” that people feign need for government supports to avoid being responsible members of society. Fear of malingering is closely tied to the American myth of self-reliance, which stigmatizes government assistance in pursuit of idealized self-sufficiency. The two sides of this coin — fear of malingering and the myth of self-reliance — feed anti-Medicaid rhetoric, which flourished during the last four years but has much deeper roots.

The fear of malingering ignores extensive data that the majority of Medicaid beneficiaries who can work do work. Further, determinations of deservingness are contrary to the purpose of the Medicaid program, which has special rules to protect low-income individuals from the significant financial and other risks of medical care. The Biden administration reversed the work requirement policy, but low-income Americans may not be protected from a political turnaround in the long-term.

The Biden administration seeks to entrench broad authority for the Secretary of the Department of Health and Human Services (HHS) to approve demonstration waivers that have indirect benefits for the health of enrollees. Even when the goals are oriented toward health equity, HHS does not have authority to

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craft an alternative Medicaid program, and a broad read of secretarial authority leaves the interpretive door wide open for the next administration. The political pendulum swings from election to election, and the next swing could be in the direction of thwarting Medicaid's statutory objectives and denying coverage to vulnerable populations.

Medicaid's Purpose

Medicaid offers federal funds to states to provide medical assistance to low-income Americans. As federal courts have held, this means Medicaid pays for medical care for low-income individuals who fit in Medicaid's categories of eligibility.¹ These have included children, parents, pregnant women, people with dis-

gress to recognize the substantial evidence that many people, especially part-time and low-wage workers, were unable to obtain ESI, could not obtain other commercial insurance, and did not qualify for Medicaid. Under the ACA, Medicaid expansion and federal tax subsidies for purchasing qualified health plans on a health insurance exchange are the two key ways that low-income people can obtain coverage, crafting a universal approach to coverage for the first time in American history. While providing important synergy, these pillars are not actually equivalent. Medicaid has four core features that protect low-income populations in ways that commercial insurance does not.

First, in contrast to the limited open enrollment of commercial insurance and Medicare's penalties for

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abilities, and the elderly. The categories of eligibility drew on the old cash assistance welfare programs that were part of Medicaid's original structure but separated by federal law during the Clinton administration. Despite that delinking, it was not until 2010 that Medicaid eligibility was expanded to cover other low-income, nonelderly adults under the Patient Protection and Affordable Care Act (ACA). The ACA eliminated the concept of deservingness for low-income people to qualify for Medicaid, though noncitizens are still treated differently.

The ACA's Medicaid eligibility expansion was a change in the historical approach to accessing health care, shifting from a norm of exclusion to inclusion, and is central to the near-universal coverage goal of the ACA. Many other nations established universal coverage after World War II, but American medical care remained driven by private transactions and individual status. People who held jobs with no benefits, non-parents, non-white, and otherwise "undeserving" populations have been excluded from care in part because they were often unable to obtain coverage and could not afford to pay out of pocket.² Medicaid's categorical eligibility was one aspect of exclusionary policy. Long-term downward trends in employer sponsored health insurance coverage (ESI), as well as continually increasing uninsurance rates, led Con-

beneficiaries who do not timely enroll in Parts B and D, Medicaid contains eligibility rules that accommodate income fluctuation and social vulnerability, such as continuous open enrollment, which allows anyone who is eligible to enroll at the moment they become impoverished enough. Second, patients cannot be denied coverage or care because of inability to pay, as the Medicaid Act limits out-of-pocket payments for those earning at or near the federal poverty level and premiums and deductibles are prohibited. Third, Medicaid provides comprehensive benefits beyond other insurers, such as non-skilled nursing home care (long term services and supports) and non-emergency medical transportation. Fourth, Medicaid contains due process and other structural protections. For example, states cannot delay enrollment for people who qualify, beneficiaries must receive notice before services are reduced or discontinued, and hearings to contest adverse actions include representation and a right to continued services until a decision is issued. Additionally, Medicaid's funding structure creates a statutory entitlement for states, which promises federal matching funds for the cost of Medicaid services and administration. By law, federal funds match state expenditures under the Medicaid Act and are not capped. This gives states crucial financial support, especially during events such as recessions or emergencies, protecting

state budgets while also ensuring that individuals who are eligible can enroll and access care.

The law is a structural determinant of health that can improve or stymie access to care for individuals and populations. The ACA's statutory expansion of Medicaid has begun to erode barriers to medical care, especially for people of color, even though the Supreme Court allowed states to opt out of expansion.³ More than six hundred studies⁴ show that Medicaid expansion increases coverage, expands access to care, improves health, and improves underlying determinants of health including job and housing stability.⁵ Medicaid expansion has reduced historic disparities in coverage and access and has improved health outcomes for Black, Hispanic, and other communities of color. Also, expansion is a financial benefit for states, with studies finding expansion leads to revenue gains and economic growth. Nevertheless, at the time of this writing, twelve states were refusing Medicaid expansion — despite the American Rescue Plan Act of 2021 sweetening the choice with an extra 5% federal funding match.

An important similarity between Medicaid and commercial insurance is often overlooked but relevant here: the substantial federal funding provided for both. Congress subsidizes commercial insurance in many ways, including not only startup funding provided to states to create exchanges and the ongoing spending to run the federal exchange, but also the individual tax subsidies for purchasing insurance on the exchanges, which cover most of the cost of subscribing for people at or near the poverty level. Additionally, ESI receives substantial federal tax benefits that inure to the benefit of both employers and employees, but this hidden tax subsidy of more than \$200 billion in foregone tax dollars every year is often ignored. The desire to subject Medicaid beneficiaries to self-reliance scrutiny does not extend to ESI or exchange-based insurance coverage, even though both are also government-funded mechanisms for financing medical care.⁶ In other words, Medicaid is treated differently, in part due to a fear of malingering and the misconception that playing by society's rules means having commercial insurance coverage, yet nearly all health insurance coverage, public and private, is heavily subsidized by the federal government.⁷ The next part examines the expansion of administrative authority that resulted in renewal of exclusionary norms during the Trump administration, which reflected fear of malingering and the longstanding assumption that civic character is reflected in insurance coverage.

Pushing Boundaries through Waivers

The HHS Secretary has limited authority under Section 1115 of the Social Security Act to permit states to implement demonstration projects that are “likely to assist in promoting the objectives” of Medicaid by waiving certain statutory provisions.⁸ Over time, the Secretary has approved demonstrations that expanded eligibility (for example, to pregnant women), increased covered services (such as prescription drugs), and altered delivery system models (managed care), all of which furthered Medicaid's objective: to furnish medical assistance.⁹ Yet, in recent years waivers have grown as a mechanism for implementing policies beyond the scope of Medicaid's enabling statute.

From 2017 through 2020, HHS exceeded the waiver boundaries set by law and the policies of prior administrations by allowing states to limit medical assistance rather than furnish it. It is not uncommon for 1115 waivers to be used to implement policy preferences. But attempting to nullify the existing law of the ACA through administrative acts pushed waiver authority to a different level of policymaking. In sum: in 2017, then-HHS Secretary Tom Price and CMS Administrator Seema Verma challenged the purpose and existence of ACA Medicaid expansion in an open letter, calling Medicaid a program for the “truly vulnerable” and denying the need for covering the expansion population.¹⁰ In January 2018, after Congress failed to repeal the ACA, HHS issued a State Medicaid Director Letter inviting waiver applications that propose “community engagement” requirements, a euphemism for work requirements. In January 2019, HHS issued a State Medicaid Director Letter inviting waiver applications to restructure Medicaid financing from a guaranteed federal match to a limited block grant or per capita caps in exchange for greater state regulatory freedom and reiterating work requirements as a goal.

To be clear, Congress never added work requirements to Medicaid, though they have been proposed and other social programs have been altered in this way. Recently, former Speaker Paul Ryan envisioned altering Medicaid to include work requirements as part of his plan for replacing the ACA, but such proposals failed. Congress is not neutral on this matter — Medicaid purposefully has not been amended to include work as a condition of enrollment; in fact, the ACA moved away from such deservingness determinations — in other words, away from the discourse of malingering and toward universalism. Likewise, even though politicians have tried to convert Medicaid to a block grant program, Congress never has done so.

HHS is not empowered to act where Congress has declined or failed to amend the law.

Yet, rather than expand the scope of eligibility, coverage, access, or other programmatic features as prior administrations have done, the Trump administration undermined Medicaid's core features through administrative policies issued when Congress would not modify Medicaid and could not repeal the ACA. No prior administration attempted to implement work requirements through 1115 waivers. Nevertheless, recent waiver approvals were aimed at rolling back Medicaid expansion by limiting eligibility and transforming Medicaid from a safety net program to something that operates more like more limited welfare programs, imposing work requirements and "training" beneficiaries for commercial insurance, especially for the expansion population. HHS encouraged states to condition eligibility on novel "personal responsibility" rules, eventually extending work requirements beyond the expansion population to adults in nonexpansion states like South Carolina.

Federal courts have vacated these waivers, holding that the HHS process for approving demonstration projects with work requirements was arbitrary and capricious. Yet, the Supreme Court took Arkansas and New Hampshire's petitions for certiorari at the urging of the Solicitor General, and the federal briefs to the Supreme Court are informative for considering the breadth of waiver authority going forward.¹¹ The U.S. argued that courts must be utterly deferential to the administrative authority of the Secretary in the realm of demonstration projects. The degree of deference demanded by the brief is remarkable, calling judicial review of waivers "circumscribed" and insisting courts ask only if the Secretary has a "rational basis" for deciding a waiver will promote Medicaid objectives. While the language of 1115 grants the Secretary broad power, it does not provide unfettered authority. Rather, section 1902 of the Medicaid Act can be waived only if a state application furthers the purpose of the Medicaid program.

To that end, the brief also argued that work promotes fiscal stability for the state and shifting to private insurance for beneficiaries. The design of the waivers in question — requiring at least 20 hours of work per week that may be fulfilled with volunteering — conflicts with this claim. By definition, volunteering provides no income and no benefits, so the denial of Medicaid eligibility would result in no public coverage and no path to commercial coverage. Government labor statistics also contradict this position, showing year after year that ESI is unavailable to part-time and low-wage workers. Further, fiscal stability means lowering costs through disenrollment; but, the evidence

weighs on the side of Medicaid expansion, which many studies show is a fiscal net benefit for states and a loss for nonexpansion states.¹²

The U.S. brief also asserted that these waivers teach beneficiary "personal responsibility," and claimed that work requirements allow states to conserve resources to serve people who are "needy" — a distinction meant to express that the expansion population does not qualify as needy and therefore is not deserving. Here, the fear of malingering is particularly clear, and the Elizabethan Poor Laws echo loudly in this approach to social programs, having been the progenitor for American laws categorizing the poor as unable to help themselves and deserving of assistance or able-bodied and unworthy of assistance. The 1601 Act for the Relief of the Poor provided money and services to "deserving" poor but sent "undeserving" and "able-bodied" poor to workhouses to avoid dependence on handouts.¹³ Deserving individuals included young children, the disabled, widows, elderly, and others unable to care for themselves. The colonies continued these classifications and categories of deservingness, which then carried into state welfare laws. These choices also appeared in early federal laws addressing health, such as the Sheppard-Towner Maternity and Infancy Act, and in grant-in-aid programs such as Aid to Families with Dependent Children (welfare) and Kerr-Mills, the precursor to Medicaid. The same categories are part of Medicaid today, though the ACA rejected deservingness for eligibility.

The use of "deserving" and "able-bodied" has become part of the law governing social programs despite the racialized history of these terms. Understanding this history is relevant to interpreting notions of self-reliance and the implications of such classifications in health policy today. The words "able-bodied" were used to advertise and value the sale of enslaved people, especially healthy men. After the Civil War, the Freedmen's Bureau classified freed enslaved people as "able-bodied" to determine the degree of their eligibility for federal assistance, which was time-limited so they could not "forget how to work."¹⁴ The term able-bodied also was used in the South as part of the Jim Crow penal system, which sent able-bodied freedmen into "convict lease" programs providing involuntary free labor to private industry after conviction — effectively re-enslaving freedmen. Being deemed able-bodied was a double-edged sword, as the work performed by slaves and those caught in the convict-lease system was unpaid, yet able-bodied freedmen were expected to be self-reliant though they had no accumulated wealth or reliable source of income. Southern Democrats blocked efforts to create national health insurance after World War II out of fear that robust social

programs would elevate agricultural, domestic, and other low-paid workers and help to eliminate segregation (which Medicare ultimately did).¹⁵ Thus, return to the use of “able-bodied” to resist the universal coverage goals of the ACA is especially pernicious.

The Trump administration’s brief pointed to the work requirements in Temporary Assistance to Needy Families (TANF, cash assistance) and Supplemental Nutrition Assistance Program (SNAP, food assistance) as evidence of success. Statutorily, those programs include the option for states to implement work requirements but Medicaid does not. And, extensive evidence shows that work requirements hasten disenrollment and do not increase employment.¹⁶ Further, the ACA already determined that people who qualify for Medicaid need government assistance, so HHS cannot reverse that legislative determination. In short, the words “personal responsibility” indicate self-reliance scrutiny of beneficiaries within social programs and echo historic fear of malingering.

In addition, the administration asserted that work “promotes health,” but this turns the evidence on its head. Barriers to health insurance coverage endanger health; many studies show that insurance coverage improves access to care and being uninsured causes people to delay or avoid care. Nevertheless, the brief stated:

Even accepting the court of appeals’ premise that the Medicaid statute’s sole objective is to provide health-care coverage, it does not follow that the Secretary may approve only demonstration projects that directly advance the provision of coverage — not those that may indirectly advance that goal. [the] text broadly authorizes “any *** demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of” Medicaid. The text contains no exception for projects to test measures that are intermediate means of advancing the Medicaid objective of furnishing medical assistance. To the contrary, by authorizing projects the Secretary deems “likely to assist in promoting” Medicaid’s objectives, the text naturally encompasses measures that are means of pursuing that end.¹⁷

Improvement of Medicaid beneficiary health was never the Trump administration’s goal. But the argument for deference to HHS authority to approve demonstrations that may indirectly support health is important to the Biden administration’s take on administrative authority, discussed in the next part.

Indirect Health Benefits and Proxies

On February 12, 2021, the Biden administration began notifying states it was evaluating whether to withdraw authorization for work requirements. HHS eliminated the 2018 policy inviting waiver applications for community engagement requirements and used the novel coronavirus pandemic as a lens for reevaluating the dangers of causing Medicaid disenrollment through work requirements. HHS then began notifying states with such waivers that it determined work-related requirements “would not promote the objectives of the Medicaid program” and approval was withdrawn.¹⁸

The individual state revocation letters, which began with Arkansas and New Hampshire (litigants before the Supreme Court), are heavily footnoted with extensive evidence regarding the harms enrollment barriers cause Medicaid beneficiaries. These letters contrast sharply with the lack of evidence for the Trump administration’s assertion that work requirements are a way to promote health. HHS also included the evidence that most beneficiaries who can work already do so, highlighting the sham reasons for instituting work requirements, which were predicted by every state to limit Medicaid enrollment — also a policy goal of HHS, which had asserted that the expansion population was not truly needy and so not deserving of Medicaid.

Yet, the Biden administration did not petition the Supreme Court to dismiss the work requirement case in its entirety, which would have left the circuit court’s decision in place. Rather, the new federal position sought to vacate the appellate court’s finding that work requirements could not satisfy the purpose of Medicaid and remand to the Secretary of HHS for further consideration.¹⁹ This procedural posture was a surprise to scholars and advocates, because the Biden administration is contesting the judicial decision that the Secretary does not have authority to approve waivers that indirectly “improve” health outcomes, much like the Trump administration had done. In short, the administration asserts that the scope of the Secretary’s authority to grant demonstration project waivers is broad, the D.C. Circuit’s decision threatens that broad power, and the Secretary’s authority should not be curtailed given how circumstances are substantially changed due to both the pandemic and HHS policy shifts.

The question of the HHS Secretary’s authority to issue waivers that may have an indirect benefit for the health of enrollees is the same claim underlying the Trump administration’s assertion that work requirements support health. This point of alignment is notable and worth analyzing.

As noted above, demonstration projects imposing work requirements are not authorized by the Med-

icaid Act and create an unlawful condition of enrollment for individuals who are entitled to medical assistance. The Trump administration's assertion that work benefits health and serves the purpose of the Medicaid program was plainly a sham. Extensive evidence from other social programs that statutorily allow work requirements, such as SNAP, shows that work requirements hasten disenrollment and deepen poverty but do not increase employment.²⁰ As such, when states predicted in their Medicaid waiver applications that thousands of people would be disenrolled by virtue of work requirements, they were relying on the very evidence put forth by the Trump administration in its defense of work requirements. Also, Arkansas' brief implementation of work requirements almost immediately disenrolled 18,000 people, many because the administrative burden was too great, and the disenrolled neither found work nor enrolled in commercial insurance.²¹ (New Hampshire had the same experience but halted implementation before disenrollment occurred, as did Indiana.) This is the kind of deceptive administrative reasoning rejected by the Supreme Court in 2019, when the Census Bureau attempted to add immigration status to census documents.²²

Executive orders and agency actions have made it clear the Biden administration has a different approach that includes centering health equity, rebuilding the ACA, and encouraging completion of Medicaid expansion in its health policy. The claim for broad secretarial discretion may be operationalized to support states submitting waiver applications to pay for determinants of health such as food and housing. Plenty of good evidence demonstrates that food security and housing improve health, but the question is whether such a broad read of administrative authority is necessary to pursue demonstrations supporting underlying determinants of health. Good nutrition directly impacts health, and poor nutrition can cause certain diseases such as type 2 diabetes. Low quality housing and being unhoused can exacerbate chronic conditions such as asthma. These are direct effects on health, and may be within the scope of secretarial authority to grant state requests to cover such services — without making broad claims about indirect effects on health.

Broad secretarial authority under the Biden administration likely would support social programs and beneficiary health and seems unlikely to rely on sham reasoning based on regulatory issuances such as the withdrawal of work requirement approval letters. But extending the reach of Medicaid, which has a statutorily defined purpose and limited funding, should not become a proxy for difficult policy debates about amending or revising other social programs. And

expanding secretarial authority around the concept of indirect health effects could become a dangerous game.

For example, Arkansas has granted a waiver to provide premium assistance for the expansion population to purchase insurance on the exchange, and the state posted a waiver application for public comment on June 14, 2021 that asks HHS exercise this “indirect benefit” authority. More specifically, Arkansas would have HHS exercise its authority in multiple and potentially conflicting ways: the application seeks to pay for connecting beneficiaries to social supports with a focus on particular vulnerable populations but also wants to require beneficiaries to show they “value” having coverage through Medicaid by paying out of pocket while also having health plans link beneficiaries to work through “economic independence initiatives.”²³ The waiver application does not seek work requirement approval, but Arkansas states it would do so should such a policy return to favor. These features seek to institute protocols that target fear of malingering.

Fear of malingering is not strictly policy that breaks along political lines. For example, President Clinton encouraged welfare reform that helped to usher in work requirements under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA).²⁴ Welfare was based on old-fashioned Mothers' Pensions, later Aid to Dependent Children, which prevented recipients from working to preserve women's limited role in society. Both Democrats and Republicans came to see this approach as problematic, but PRWORA embraced an anti-malingering policy that ended the cash assistance statutory entitlement, encouraging states to institute work requirements and time-limited eligibility while limiting federal funds. Researchers have found that PRWORA made low-income populations more vulnerable to the Great Recession, because many low-income individuals became more impoverished yet had no path to the safety net and no possible employment when the economy crashed.²⁵

Advocates who support the Biden administration's broad administrative authority should bear such examples in mind, as the Arkansas waiver application and others like it may put the Biden administration's approach to the test. How far can the Secretary go in supporting “indirect effects” on health? Many who want to support vulnerable populations see Medicaid as a source of funding for basic needs, understanding that all determinants of health are relevant factors in the health of low-income people and are difficult to address individually. But, another administration could share the perception that Medicaid is not public insurance, and it could use the very same authority to

shred the safety net — a lesson that must be learned from the last four years.

Conclusion

Singling out “able-bodied” adults for self-reliance scrutiny through work requirements reverted to a pre-ACA, exclusionary approach to accessing health care that has deeply discriminatory roots. This is an approach that defies the law as well as data regarding work and insurance coverage, and it is harmful to low-income people who rely on social programs. Though the Biden administration may have evidence-based individual and public health policy goals, advocacy before the Supreme Court arguing for a very broad and largely unreviewable scope of administrative authority raises questions. Section 1115 is not a green light for administratively implementing an alternative Medicaid program. The policy pendulum swings with each administration, and the next one may contradict Medicaid’s statutory objectives and deny coverage to vulnerable populations.

Note

The author has no conflicts to disclose.

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