

MEDICAID AND OPIOIDS: FROM PROMISING PRESENT TO PERILOUS FUTURE

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ABSTRACT

Medicaid is at the core of the opioid overdose epidemic. Both state and federal government reactions continue to shape the outcomes of this epidemic while death rates in some states continue to increase. There is a strong correlation between those suffering from opioid use disorder and those eligible for Medicaid. Most significantly, individuals with opioid use disorder enrolled in their state's Medicaid program experience greater positive health outcomes compared to those without coverage. Furthermore, states with expanded Medicaid coverage tend to positively impact social determinants of health for individuals with opioid use disorder. Notwithstanding these critical figures, the positive, ameliorative implementation of Medicaid programs is under attack as several states are erecting new work-requirement rules and the federal government is pushing for a block grant funding model, all of which will make access to health insurance more difficult for those suffering from opioid use disorder.

TABLE OF CONTENTS

INTRODUCTION.....	866
I. THE OUD POPULATION	867
II. ACCESS TO CARE THROUGH MEDICAID	869
A. Insurance Status of Those with Opioid Use Disorder	869
B. Expanded Medicaid	870
C. Section 1115 Waivers	872
III. WORK REQUIREMENTS AND FELLOW TRAVELERS	873
IV. THE SPECTER OF BLOCK GRANTS AND THE LIMITS OF FEDERAL FUNDING	882
CONCLUSION	886

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INTRODUCTION

Medicaid occupies a central position in the federal and state governments' reactions to the opioid overdose epidemic. First, there is a strong correlation between those suffering from opioid use disorder (OUD) and those eligible for Medicaid. Second, the funding mechanisms for both original Medicaid and expanded Medicaid allow for hard-hit states to expand their expenditures on opioid interventions knowing that the federal government will cover a disproportionate amount of the costs. Third, Medicaid comes complete with a built-in statutory waiver process whereby the federal government may approve applications from states for demonstration projects targeted at specific issues or populations, of which behavioral health is an obvious example.

Notwithstanding its promise in the opioid context, Medicaid, like other types of U.S. public and private health insurance, is part of a poorly functioning health care system that, *inter alia*, creates barriers because of the way it segments populations with different eligibility and benefits. As such, even when functioning properly, its application processes, eligibility rules, and benefit limitations are responsible for creating structural determinants that impede access to needed diagnosis, treatment, and recovery services.¹ Worse, Medicaid is not functioning in a way that best addresses opioid use, suggesting a perilous future for those who rely on it. First, not all states have adopted the Affordable Care Act (ACA) enhanced matching known as Medicaid expansion.² Second, while Medicaid expansion removes one structural determinant by increasing the Medicaid-eligible population, several states are now erecting new rules, including changes to eligibility, that will actually make access more difficult for those suffering from OUD. Third, Medicaid remains under a more existential threat as the inexorable churn of U.S. policy-politics once again brings up the issue of converting Medicaid from a federal-state matching model to one using block grants that will drastically reduce coverage.

This Essay proceeds as follows: Section I notes the correlation between the population suffering from OUD, a subset of substance use disorder (SUD),³ and Medicaid eligibility. Section II examines the access to care provided both by original Medicaid and, subsequently, the enhanced match. Section III examines recent attempts to reduce Medicaid eligibility by imposing work requirements and administrative requirements. Section IV examines the current state of federal funding in response to the opioid overdose crisis and the specter of block grants. This essay concludes that, both within and beyond the substance use frame, a state's refusal to expand Medicaid or to reduce eligibility is not an example of fiscal responsibility but the punishment of the state's poor and sick.

1. See generally Nicolas P. Terry, *Structural Determinism Amplifying the Opioid Crisis: It's the Healthcare, Stupid!*, 11 NE. U. L. REV. 315 (2019).

2. *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (Feb. 19, 2020), <http://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/> [<https://perma.cc/KYY4-X8MP>]. See generally Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.).

3. See generally Deborah S. Hasin et al., *DSM-5 Criteria for Substance Use Disorders: Recommendations and Rationale*, 170 AM. J. PSYCHIATRY 834 (2013).

I. THE OUD POPULATION

There seems to be little disagreement with the conclusion that the root causes of the opioid overdose epidemic and prior drug crises, as well as the HIV epidemic, are “social and structural and are intertwined with genetic, behavioral, and individual factors.”⁴ Social determinants include “socioeconomic status, education, neighborhood and physical environment, employment, and social support networks, as well as access to health care.”⁵ “Structural determinants include architectural, economic, or political frameworks that create barriers to remediating social determinants or perpetuate social determinants such as health inequities.”⁶ Thus, the absence of health care caused by the absence of health insurance (for example, living in a state that has not expanded Medicaid) is a social determinant while processes that increase friction regarding Medicaid eligibility (for example, community engagement) are structural determinants.

Even to the untrained eye, the correlation between maps showing county-level economic distress,⁷ county-level drug mortality,⁸ and state health system performance⁹ is startling. Opioid use is strongly correlated with low incomes or poverty: “In 2017, 49% of adults with OUD had incomes below 200% [Federal Poverty Level (FPL)] . . . compared to only 34% of all nonelderly adults [A]lmost a quarter (23%) of those with OUD were poor compared to just 15% of all nonelderly adults.”¹⁰ This is at a time when income inequality has reached its highest level in fifty years.¹¹

The well-known “Deaths of Despair” study by Anne Case and Angus Deaton concluded that “progressively worsening labor market opportunities at the time of entry for whites with low levels of education” caused an increase in drug overdoses, suicides,

4. See Nabarun Dasgupta et al., *Opioid Crisis: No Easy Fix to Its Social and Economic Determinants*, 108 AM. J. PUB. HEALTH 182, 185 (2018).

5. SAMANTHA ARTIGA & ELIZABETH HINTON, BEYOND HEALTH CARE: THE ROLE OF SOCIAL DETERMINANTS IN PROMOTING HEALTH AND HEALTH EQUITY 2 fig.1 (2018), <http://files.kff.org/attachment/issue-brief-beyond-health-care> [<https://perma.cc/8AZE-ZHKF>] (noting health coverage, provider availability, provider linguistic and cultural competency, and quality of care as social determinants).

6. Terry, *supra* note 1, at 325.

7. Christopher Ingraham, *Each County in the United States, Ranked by Economic Distress*, WASH. POST (Sept. 26, 2017, 1:34 PM), <http://www.washingtonpost.com/news/wonk/wp/2017/09/26/every-county-in-america-ranked-by-economic-distress/> [<https://perma.cc/CEX4-7Q5W>].

8. Laura Dwyer-Lindgren et al., *Trends and Patterns of Geographic Variation in Mortality from Substance Use Disorders and Intentional Injuries Among US Counties, 1980-2014*, 319 JAMA 1013, 1019 (2018).

9. DAVID C. RADLEY ET AL., THE COMMONWEALTH FUND, 2019 SCORECARD ON STATE HEALTH SYSTEM PERFORMANCE 17 (2019), http://scorecard.commonwealthfund.org/files/Radley_State_Scorecard_2019.pdf [<https://perma.cc/Y33N-SPXW>].

10. KENDAL ORGERA & JENNIFER TOLBERT, KAISER FAMILY FOUND., THE OPIOID EPIDEMIC AND MEDICAID’S ROLE IN FACILITATING ACCESS TO TREATMENT 2 (2019), <http://files.kff.org/attachment/Issue-Brief-The-Opioid-Epidemic-and-Medicoids-Role-in-Facilitating-Access-to-Treatment> [<https://perma.cc/47G3-WZGD>].

11. Associated Press, *Income Inequality at Highest Level in More Than 50 Years, Census Figures Show*, L.A. TIMES (Sept. 26, 2019, 12:59 AM), <http://www.latimes.com/business/story/2019-09-26/income-inequality-grows-census> [<https://perma.cc/J2VX-D7B9>].

and alcohol-related deaths.¹² Subsequently, a 2019 study by Rebecca Haffajee and colleagues found that higher unemployment was associated with high-risk opioid counties.¹³

Although the social and structural causes and contexts of the opioid overdose epidemic are clear, the immensity of the tragedy continues to unfold. Recent data have led some to suggest that the opioid overdose epidemic has plateaued.¹⁴ However, the dip in U.S. death rates is modest at best, with late 2019 and early 2020 monthly data showing single digit declines year-on-year.¹⁵ For example, the data released in February 2020, reflecting deaths from July 2018 to July 2019, showed a decline of just 0.8%.¹⁶ Additionally, the data deserve some disaggregation. Thus, although former epicenter states such as Indiana, Ohio, Kentucky, and West Virginia showed double-digit drops in 2019, more recent data show more modest gains (with Ohio showing a slight increase) while others such as California, Delaware, New Mexico, and Alaska have reported double-digit upward spikes.¹⁷ Furthermore, even with the improvements, the current annual death rate—over seventy thousand—still exceeds the nation’s peak yearly historical deaths from car accidents, AIDS, or gun violence.¹⁸ Most importantly, although there has been a decline in deaths from prescription opioids, the death toll from synthetic opioids such as fentanyl continues to increase, as do deaths from other drugs such as potent forms of methamphetamine.¹⁹

As a country and for several decades, the United States has become acclimated to increases in life expectancy.²⁰ However, after 2010 death rates once again began to climb,²¹ and among adults aged twenty-five through forty-four, death rates increased

12. Anne Case & Angus Deaton, *Mortality and Morbidity in the 21st Century*, BROOKINGS PAPERS ON ECON. ACTIVITY, Spring 2017, at 397, 397–98, <http://www.brookings.edu/wp-content/uploads/2017/08/casetextsp17bpea.pdf> [<https://perma.cc/F2NX-29B3>].

13. Rebecca L. Haffajee et al., *Characteristics of US Counties with High Opioid Overdose Mortality and Low Capacity To Deliver Medications for Opioid Use Disorder*, JAMA NETWORK OPEN, June 2019, at 1, 6, <http://jamanetwork.com/journals/jamanetworkopen/fullarticle/2736933> [<https://perma.cc/MCN6-FMK7>]; see also ROBIN GHERTNER & LINCOLN GROVES, U.S. DEP’T OF HEALTH & HUMAN SERVS., THE OPIOID CRISIS AND ECONOMIC OPPORTUNITY: GEOGRAPHIC AND ECONOMIC TRENDS 8–9 (2018), <http://aspe.hhs.gov/system/files/pdf/259261/ASPEconomicOpportunityOpioidCrisis.pdf> [<https://perma.cc/HG93-PMGY>].

14. Emma Newburger, *White House Touts Progress in Opioid Crisis, but Health Researchers Are Skeptical*, CNBC (Mar. 26, 2019, 9:45 AM), <http://www.cnbc.com/2019/03/26/white-house-touts-progress-in-opioid-crisis-but-some-are-skeptical.html> [<https://perma.cc/2J77-4ZDW>].

15. *Provisional Drug Overdose Death Counts*, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 4, 2019), <http://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm> [<https://perma.cc/42VM-K7DY>] (reviewing the 12 Month-ending Provisional Counts and Percent Change of Drug Overdose Deaths).

16. *Id.*

17. *Id.*

18. Josh Katz & Margot Sanger-Katz, ‘*The Numbers Are So Staggering.*’ *Overdose Deaths Set a Record Last Year*, N.Y. TIMES (Nov. 29, 2018), <http://www.nytimes.com/interactive/2018/11/29/upshot/fentanyl-drug-overdose-deaths.html> [<https://perma.cc/Z2YB-FGVB>].

19. *Provisional Drug Overdose Death Counts*, *supra* note 15 (reviewing the 12 Month-ending Provisional Number of Drug Overdose Deaths by Drug or Drug Class for synthetic opioids, excluding methadone).

20. See Steven H. Woolf & Heidi Schoemaker, *Life Expectancy and Mortality Rates in the United States, 1959-2017*, 322 JAMA 1996, 1998 (2019).

21. *Id.*

dramatically.²² The largest increases in midlife mortality rates have occurred in New England and the Ohio Valley, regions closely associated with the worst of the opioid overdose epidemic.²³

II. ACCESS TO CARE THROUGH MEDICAID

Medicaid covers more than seventy-five million persons, including the poorest and most vulnerable.²⁴ It consists of state-administered programs that the federal government disproportionately finances.²⁵ States with lower income populations receive a higher federal medical assistance percentage (FMAP) share under original Medicaid,²⁶ and all can enjoy the enhanced 90–100% match provided through Medicaid expansion.²⁷ Approximately two million persons suffer from OUD although a 2018 McKinsey report took the position that these are underestimates with the likely number being between four and six million persons.²⁸ Part II.A details access to health care services through Medicaid is of the greatest importance to a large proportion of those suffering from OUD. This Part first notes the extreme importance of Medicaid because of its dominant role in providing health care access to the OUD cohort. Second, Part II.B discusses the potential for increased access to treatment for OUD and SUD cohorts through the enhanced match under Medicaid expansion, along with the negative correlates associated with nonexpansion. Finally, Part II.C explains the role of section 1115 waivers to expand eligibility or benefits.

A. Insurance Status of Those with Opioid Use Disorder

Almost twenty percent of nonelderly adults with OUD, predominantly young white males, lack any insurance and—emergency services or some community clinics aside—are unlikely to receive treatment or recovery services.²⁹ Approximately thirty-four percent of nonelderly adults have private insurance, and slightly more

22. Betsy McKay, *Death Rates Rising for Young, Middle-Aged U.S. Adults*, WALL STREET J. (July 23, 2019, 12:03 AM), <http://www.wsj.com/articles/death-rates-rising-for-young-middle-aged-u-s-adults-11563854580> [<https://perma.cc/3UF2-J2RX>].

23. Woolf & Schoemaker, *supra* note 20, at 2003.

24. ROBIN RUDOWITZ ET AL., KAISER FAMILY FOUND., 10 THINGS TO KNOW ABOUT MEDICAID: SETTING THE FACTS STRAIGHT 4 (2019) [hereinafter RUDOWITZ ET AL., 10 THINGS TO KNOW ABOUT MEDICAID], <http://files.kff.org/attachment/Issue-Brief-10-Things-to-Know-about-Medicaid-Setting-the-Facts-Straight> [<https://perma.cc/VMY5-52HD>].

25. *Id.* at 8.

26. LAURA SNYDER & ROBIN RUDOWITZ, KAISER FAMILY FOUND., MEDICAID FINANCING: HOW DOES IT WORK AND WHAT ARE THE IMPLICATIONS? 3 (2015), <http://files.kff.org/attachment/issue-brief-medicaid-financing-how-does-it-work-and-what-are-the-implications> [<https://perma.cc/6DHP-NP88>].

27. ROBIN RUDOWITZ, KAISER FAMILY FOUND., UNDERSTANDING HOW STATES ACCESS THE ACA ENHANCED MEDICAID MATCH RATES 2 (2014), <http://files.kff.org/attachment/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates-issue-brief> [<https://perma.cc/M7SM-N5K2>].

28. Sarun Charumilind et al., *Why We Need Bolder Action To Combat the Opioid Epidemic*, MCKINSEY & CO. (Sept. 2018), <http://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/why-we-need-bolder-action-to-combat-the-opioid-epidemic> [<https://perma.cc/2F2Y-LGBV>].

29. KENDAL ORGERA & JENNIFER TOLBERT, KAISER FAMILY FOUND., KEY FACTS ABOUT UNINSURED ADULTS WITH OPIOID USE DISORDER 1–2, 5 (2019), <http://files.kff.org/attachment/Data-Note-Key-Facts-about-Uninsured-Adults-with-Opioid-Use-Disorder> [<https://perma.cc/5KQT-HNHN>].

(thirty-eight percent) have Medicaid coverage.³⁰ Crucially, Medicaid covers fifty-five percent of low-income adults with OUD.³¹ The impact of that public insurance coverage is profound. Those with Medicaid were nearly twice as likely as those with private insurance to have received drug and/or alcohol treatment.³²

B. Expanded Medicaid

Given the relationship between those with low incomes or in poverty, OUD, and the positive impact of Medicaid, extending the Medicaid umbrella beyond 100% to 138% FPL with the ACA enhanced match would have a meaningful impact on the availability of health care for those with OUD. Indeed, the Surgeon General recognized this in his 2016 report on addiction in the United States, noting it as “a key lever for expanding access to substance use treatment because many of the most vulnerable individuals with substance use disorders have incomes below 138 percent of the federal poverty level.”³³

However, the aftermath of the Supreme Court decision in *National Federation of Independent Business v. Sebelius*³⁴ that rendered Medicaid expansion voluntary for the states impeded the ability to reach many in the FPL cohort.³⁵ Approximately 2.5 million poor uninsured persons have thus found themselves without coverage because their states of residence have refused to expand Medicaid.³⁶ Given the correlation between the poor and OUD, this needlessly uninsured cohort may include five hundred thousand or more persons suffering from OUD.

As of February 2020, fourteen states had not opted to expand Medicaid, while three more had decided to expand but, with some local contention, had not yet implemented the expansion.³⁷ Many of the midwestern and Appalachian overdose epidemic states, such as Indiana, Ohio, and West Virginia, have expanded Medicaid (some tempted by section 1115 waivers as Part III.C discusses).³⁸ Others, such as Missouri and Kansas, have not.³⁹ However, the largest cluster of nonexpansion states is in the deep south plus Texas,⁴⁰ reinforcing the broader point that, in health care, we are faced with “two Americas.”⁴¹

30. ORGERA & TOLBERT, *supra* note 10, at 3.

31. *Id.*

32. *Id.* at 4 (highlighting the rate difference of forty-four percent versus twenty-four percent).

33. OFFICE OF THE SURGEON GEN., U.S. DEP'T OF HEALTH & HUMAN SERVS., FACING ADDICTION IN AMERICA: THE SURGEON GENERAL'S REPORT ON ALCOHOL, DRUGS, AND HEALTH, at 6–7 (2016).

34. 567 U.S. 519 (2012).

35. *Sebelius*, 567 U.S. at 588.

36. RACHEL GARFIELD ET AL., KAISER FAMILY FOUND., THE COVERAGE GAP: UNINSURED POOR ADULTS IN STATES THAT DO NOT EXPAND MEDICAID 6 tbl.1 (2020), <http://files.kff.org/attachment/Issue-Brief-The-Coverage-Gap-Uninsured-Poor-Adults-in-States-that-Do-Not-Expand-Medicaid> [<https://perma.cc/T9HQ-ZADD>].

37. *Status of State Medicaid Expansion Decisions*, *supra* note 2.

38. *Id.*

39. *Id.*

40. *Id.*

41. Cathy Schoen et al., *Health Care in the Two Americas: Findings from the Scorecard on State Health System Performance for Low-Income Populations, 2013*, COMMONWEALTH FUND (Sept. 18, 2013),

Worryingly, the overall decrease in the number of uninsured that began after the implementation of the ACA has now levelled off and may even be reversing.⁴² This shift is particularly the case in nonexpansion states that average twice the percentage of uninsured adults compared to expansion states.⁴³ There is also evidence that expansion has a “welcome mat” effect whereby those eligible but not previously enrolled (particularly children) acquire coverage when family members enroll thanks to the enhanced match.⁴⁴

A study of four expansion states found that between twenty and thirty-four percent of those in the expansion cohort had availed themselves of covered substance use or mental health services, while state officials noted a sharp increase in their use of medication-assisted treatment.⁴⁵ The impact of expansion goes far beyond simple numbers of insureds. A 2019 literature review highlighted the correlation of expansion with, inter alia, increased utilization of services, improved self-reported health, positive health outcomes, state budget savings, gains in employment, and overall economic growth.⁴⁶

Expansion states saw a decrease in uninsured SUD hospitalizations from approximately twenty percent in 2013 to about five percent in 2015.⁴⁷ After Kentucky expanded Medicaid, the state experienced a 700% increase in the utilization of substance use services.⁴⁸ Medicaid expansion also increased access to the overdose reversal drug naloxone; prior to expansion the number of Medicaid-covered naloxone prescriptions was relatively flat, but, thereafter in 2016, expansion states dispensed more than thirty-eight thousand naloxone prescriptions, compared with only seven thousand in nonexpansion states.⁴⁹ Although, overall, the availability of medications

<http://www.commonwealthfund.org/publications/fund-reports/2013/sep/health-care-two-americas-findings-sco-recard-state-health-system> [<https://perma.cc/73M2-G36W>].

42. RACHEL GARFIELD ET AL., KAISER FAMILY FOUND., *THE UNINSURED AND THE ACA: A PRIMER* 7 (2019), <http://files.kff.org/attachment/The-Uninsured-and-the-ACA-A-Primer-Key-Facts-about-Health-Insurance-and-the-Uninsured-amidst-Changes-to-the-Affordable-Care-Act> [<https://perma.cc/A8K3-3PM5>].

43. Jennifer Haley et al., *Adults' Uninsurance Rates Increased By 2018, Especially in States That Did Not Expand Medicaid—Leaving Gaps in Coverage, Access, and Affordability*, HEALTH AFF. BLOG (Sept. 26, 2018), <http://www.healthaffairs.org/doi/10.1377/hblog20180924.928969/full/> [<https://perma.cc/8WUC-D9RJ>].

44. Julie L. Hudson & Asako S. Moriya, *Medicaid Expansion for Adults Had Measurable 'Welcome Mat' Effects on Their Children*, 36 HEALTH AFF. 1643, 1649 (2017).

45. Hannah Katch, *Medicaid Expansion Is Critical for States Fighting Opioid Epidemic*, CTR. ON BUDGET & POL'Y PRIORITIES (Oct. 4, 2017, 3:15 PM), <http://www.cbpp.org/blog/medicaid-expansion-is-critical-for-states-fighting-opioid-epidemic> [<https://perma.cc/AN6M-US8X>].

46. LARISA ANTONISSE ET AL., KAISER FAMILY FOUND., *THE EFFECTS OF MEDICAID EXPANSION UNDER THE ACA: UPDATED FINDINGS FROM A LITERATURE REVIEW* 1–2 (2019), <http://files.kff.org/attachment/Issue-brief-The-Effects-of-Medicaid-Expansion-under-the-ACA-Findings-from-a-Literature-Review> [<https://perma.cc/9U8W-5TK6>].

47. OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, U.S. DEP'T OF HEALTH & HUMAN SERVS., *CONTINUING PROGRESS ON THE OPIOID EPIDEMIC: THE ROLE OF THE AFFORDABLE CARE ACT* 2 (2017), <http://aspe.hhs.gov/system/files/pdf/255456/ACAOpoid.pdf> [<https://perma.cc/HV3R-CRNB>].

48. FOUND. FOR A HEALTHY KY., *SUBSTANCE USE AND THE ACA IN KENTUCKY* 1 (2016), http://www.healthy-ky.org/res/images/resources/Full-Substance-Use-Brief-Final_12_16-002-.pdf [<https://perma.cc/2HVL-3AQ2>].

49. Richard G. Frank & Carrie E. Fry, *The Impact of Expanded Medicaid Eligibility on Access to Naloxone*, 114 ADDICTION 1567, 1571 (2019).

for OUD treatment in residential treatment settings is critically low, the situation in expansion states is better.⁵⁰ One study of prescribing trends before and after expansion found no meaningful increase in opioid prescriptions but substantial increases in prescriptions used to treat OUD.⁵¹ Another study showed a strong correlation between Medicaid expansion and large-scale increases in access to buprenorphine treatment prescriptions.⁵² The enhanced match also appears to impact social determinants with one study suggesting that Medicaid expansion is associated with a reduction in the number of evictions and so promotes housing stability.⁵³ Finally, a recent county-level, nationwide study found Medicaid expansion was associated with a six percent lower rate of opioid overdose deaths.⁵⁴

C. Section 1115 Waivers

Beyond core requirements such as eligibility and required benefits, the states have considerable discretion in setting up their Medicaid programs. Additionally, section 1115 of the Social Security Act permits the Secretary of Health and Human Services (HHS) to waive compliance with some aspects of the Medicaid law for demonstration projects.⁵⁵ These waivers are subject to budget neutrality and the promotion of the objectives of the Medicaid program.⁵⁶ Waivers must also comply with four “guardrails,” including increasing and strengthening the overall coverage of low-income individuals and improving the health outcomes for Medicaid and other low-income populations.⁵⁷

Typically, section 1115 waivers have been used to expand eligibility or benefits, and states frequently have applied for waivers to provide them more flexibility as they react to the opioid overdose epidemic.⁵⁸ The Centers for Medicare & Medicaid Services (CMS) has explicitly encouraged this approach, for example, noting in a 2017 letter to state Medicaid directors that “CMS would like to partner with states to support ways to progressively improve outcomes for Medicaid beneficiaries struggling with

50. See Andrew S. Huhn et al., *Differences in Availability and Use of Medications for Opioid Use Disorder in Residential Treatment Settings in the United States*, JAMA NETWORK OPEN, Feb. 2020, at 1, 5, <http://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760443> [<https://perma.cc/9B7J-CSLX>].

51. Benjamin A.Y. Cher et al., *Medicaid Expansion and Prescription Trends: Opioids, Addiction Therapies, and Other Drugs*, 57 MED. CARE 208, 211 (2019).

52. LISA CLEMANS-COPE ET AL., URBAN INST., STATE VARIATION IN MEDICAID PRESCRIPTIONS FOR OPIOID USE DISORDER FROM 2011 TO 2018, at 13 (2019), http://www.urban.org/sites/default/files/publication/100817/2019.08.19_av_state_medicaid_rx_oud_final_v3_4.pdf [<https://perma.cc/H8BZ-4TH8>].

53. Heidi L. Allen et al., *Can Medicaid Expansion Prevent Housing Evictions?*, 38 HEALTH AFF. 1451, 1454–55 (2019).

54. Nicole Kravitz-Wirtz et al., *Association of Medicaid Expansion with Opioid Overdose Mortality in the United States*, JAMA NETWORK OPEN, Jan. 2020, at 1, 6, <http://jamanetwork.com/journals/jamanetworkopen/fullarticle/2758476> [<https://perma.cc/WH88-B5YL>].

55. 42 U.S.C. § 1315 (2018).

56. NAT'L CONF. OF STATE LEGISLATORS, UNDERSTANDING MEDICAID SECTION 1115 WAIVERS: A PRIMER FOR STATE LEGISLATORS 4, 6 (2017), http://www.ncsl.org/Portals/1/Documents/Health/Medicaid_Waivers_State_31797.pdf [<https://perma.cc/8HEX-8AGP>].

57. *Id.*

58. ORGERA & TOLBERT, *supra* note 10, at 5.

addiction in the context of 5-year demonstrations.”⁵⁹ That letter highlighted CMS’s willingness to waive the venerable Institutions for Mental Diseases exclusion that for decades had prohibited states from reimbursing certain residential treatment facilities that provided some types of inpatient treatment.⁶⁰ States also have requested or have been granted waivers to expand community-based behavioral health benefits such as case management, supportive housing, and job coaching.⁶¹ Similarly, section 1115 waivers have sought to expand Medicaid coverage for cohorts with behavioral health needs beyond 138% FPL or to better integrate physical and behavioral health services.⁶² In a 2018 speech before the National Association of Medicaid Directors, Secretary of HHS Alex M. Azar headlined state initiatives through Medicaid waivers in increasing the number of residential treatment centers and supporting outpatient care coordination.⁶³

Of particular interest are waivers designed to use Medicaid funding for providing wraparound services because of the growing evidence base that addressing patients’ social and behavioral needs reduces subsequent hospitalizations and emergency room visits.⁶⁴ Even more important may be upstream interventions designed to tackle social determinants of health. For example, North Carolina was granted a waiver for a managed-care-based program designed to pilot programs to address housing instability, transportation insecurity, and food insecurity.⁶⁵

III. WORK REQUIREMENTS AND FELLOW TRAVELERS

During the second term of the Obama administration, Medicaid expansion essentially stalled. The administration therefore determined to make expansion more attractive to some hold-out states by approving some conservative “skin in the game” health policies designed to increase personal responsibility in making health care

59. Letter from Brian Neale, Dir., Ctrs. for Medicare and Medicaid Servs., to State Medicaid Directors (Nov. 1, 2017), <http://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf> [https://perma.cc/3LUJ-STH8].

60. *Id.* (“CMS can waive certain federal requirements . . . Ordinarily such residential treatment services are not eligible for federal Medicaid reimbursement due to the exclusion in the Medicaid statute of services provided to patients in institutions for mental diseases . . .”).

61. See *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, KAISER FAM. FOUND. (Feb. 28, 2020), <http://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/> [https://perma.cc/JU5G-VYZU] (noting that seventeen states have waivers for community-based benefit expansions).

62. MARYBETH MUSUMECI, KAISER FAMILY FOUND., KEY THEMES IN MEDICAID SECTION 1115 BEHAVIORAL HEALTH WAIVERS 6–7 (2017), <http://files.kff.org/attachment/Issue-Brief-Key-Themes-in-Medicaid-Section-1115-Behavioral-Health-Waivers> [https://perma.cc/3YLT-UABY].

63. Alex M. Azar II, Sec’y, U.S. Dep’t of Health & Human Serv., Remarks to the National Association of Medicaid Directors (Nov. 13, 2018), <http://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-to-the-national-association-of-medicaid-directors.html> [https://perma.cc/7UKZ-PFVB].

64. Joshua R. Vest et al., *Indianapolis Provider’s Use of Wraparound Services Associated with Reduced Hospitalizations and Emergency Department Visits*, 37 HEALTH AFF. 1555, 1559 (2018).

65. See Letter from Angela D. Garner, Dir., Div. of Sys. Reform Demonstrations, Ctrs. for Medicare and Medicaid Servs., to Dave Richard, Deputy Sec’y for Med. Assistance, N.C. Dep’t of Health and Human Servs. (Aug. 15, 2019), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/Medicaid-Reform/nc-medicaid-reform-eval-des-appv-ltr-20190815.pdf> [https://perma.cc/M3BL-65JF].

decisions, such as charging premiums (and lockouts for failing to pay them), penalizing nonemergency use of emergency departments, and incentivizing healthy behaviors.⁶⁶

The canary in the coal mine for this effort was the “Healthy Indiana Plan 2.0” (HIP 2.0): a waiver that the administration approved after Indiana dropped its request for a work requirement.⁶⁷ The key feature of HIP 2.0 was the enrollment of expansion persons (101–138% FPL) into an expanded benefits package for which they were charged a monthly premium;⁶⁸ failure to pay the premiums resulted in loss of benefits and a six-month “lock-out.”⁶⁹ In addition, nonexpansion persons could pay a premium that gave them access to a more comprehensive benefit package but without the lockout for failure to contribute.⁷⁰ Analysis of HIP 2.0 painted a picture of a less than successful program; almost sixty percent of nonexpansion persons never enrolled or were disenrolled for failing to pay premiums, while fifty-one percent of expansion persons never enrolled or lost coverage.⁷¹ The same research pointed to affordability and confusion about the payment process as the primary reasons for nonenrollment or loss of enrollment.⁷² It takes little imagination to conclude that those suffering from OUD and concomitant housing or financial insecurity were likely to feature disproportionality in those who failed to enroll or lost enrollment.

Following the election of President Trump, attention has turned to a far more insidious threat to Medicaid expansion and what should have been its pivotal role in alleviating the opioid crisis. In 2017, CMS Administrator Seema Verma and then-HHS Secretary Tom Price wrote to the country’s governors arguing, “The expansion of Medicaid through the [ACA] to non-disabled, working-age adults without dependent children was a clear departure from the core, historical mission of the program. . . . The best way to improve the long-term health of low-income Americans is to empower

66. See Lilliard E. Richardson Jr., *Medicaid Expansion During the Trump Presidency: The Role of Executive Waivers, State Ballot Measures, and Attorney General Lawsuits in Shaping Intergovernmental Relations*, 49 PUBLIUS 437, 443 (2019).

67. See Shari Rudavsky, *Gov. Pence Gets Federal OK for Medicaid Alternative*, INDYSTAR (Jan. 27, 2015, 10:17 AM), <http://www.indystar.com/story/news/politics/2015/01/27/gov-pence-gets-federal-ok-medicaid-alternative/22396503/> [https://perma.cc/8UCN-TN9M].

68. See Letter from Marilyn Tavenner, Adm’r, Ctrs. for Medicare and Medicaid Servs., to Joseph Moser, Medicaid Dir., Ind. Family and Soc. Servs. Admin. (Jan. 27, 2015), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-health-indiana-plan-support-20-appvl-01272015.pdf> [https://perma.cc/6PJU-W4ES].

69. ROBIN RUDOWITZ ET AL., KAISER FAMILY FOUND., DIGGING INTO THE DATA: WHAT CAN WE LEARN FROM THE STATE EVALUATION OF HEALTHY INDIANA (HIP 2.0) PREMIUMS 2 (2018) [hereinafter RUDOWITZ ET AL., DIGGING INTO THE DATA], <http://files.kff.org/attachment/Issue-Brief-Digging-Into-the-Data-What-Can-We-Learn-from-the-State-Evaluation-of-Healthy-Indiana-HIP-20-Premiums> [https://perma.cc/2KBW-WHY6].

70. THE LEWIN GROUP, INC., HEALTHY INDIANA PLAN 2.0: POWER ACCOUNT CONTRIBUTION ASSESSMENT, at i (2017), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-health-indiana-plan-support-20-POWER-acct-cont-as-sesmnt-03312017.pdf> [https://perma.cc/BMM3-MWJ2].

71. See RUDOWITZ ET AL., DIGGING INTO THE DATA, *supra* note 69, at 1.

72. *Id.*

them with skills and employment.”⁷³ Tying work to health care exposes the perverseness of path-dependent history of U.S. health care that has tied health care to employer-provided insurance. However, as the Verma-Price letter makes clear,⁷⁴ approving work requirements is an explicit attempt to reframe Medicaid as welfare rather than health insurance. Long a conservative goal, adding work requirements to other social safety net programs, such as those that the Clinton administration added to the Temporary Assistance for Needy Families and the Supplemental Nutrition Assistance Program (SNAP), has had little impact on either increased employment or reduced poverty.⁷⁵

As of January 2020, ten states had been granted work-requirement waivers, and eight other states had applied.⁷⁶ There are salient differences in the scope of the work requirements. For example, the Arkansas and New Hampshire requirements only apply to the expansion population,⁷⁷ whereas Indiana⁷⁸ and Kentucky⁷⁹ apply the requirements to both traditional and expansion populations, but South Carolina applies the requirement to subsets of its traditional Medicaid population.⁸⁰ However, in general, these modifications to Medicaid eligibility all require 80 to 100 hours of

73. Letter from Thomas E. Price, Sec’y, U.S. Dep’t of Health & Human Servs., and Seema Verma, Adm’r, Ctrs. for Medicare and Medicaid Servs., to U.S. State Governors 1–2 (Mar. 14, 2017), <http://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf> [https://perma.cc/P3ZC-7SBK].

74. *Id.* (“It is our intent to use existing Section 1115 demonstration authority to review and approve meritorious innovations that build on the human dignity that comes with training, employment and independence.”).

75. HEATHER HAHN ET AL., URBAN INST., WORK REQUIREMENTS IN SOCIAL SAFETY NET PROGRAMS 1–2 (2017), <http://www.urban.org/sites/default/files/publication/95566/work-requirements-in-social-safety-net-programs.pdf> [https://perma.cc/8XC4-4KLU].

76. *Status of Medicaid Expansion and Work Requirement Waivers*, COMMONWEALTH FUND (Jan. 3, 2020), <http://www.commonwealthfund.org/publications/maps-and-interactives/2020/jan/status-medicaid-expansion-and-work-requirement-waivers> [https://perma.cc/E4UE-P2BQ].

77. JENNIFER WAGNER & JESSICA SCHUBEL, CTR. ON BUDGET AND POLICY PRIORITIES, STATES’ EXPERIENCES CONFIRMING HARMFUL EFFECTS OF MEDICAID WORK REQUIREMENTS 1 (Oct. 22, 2019), <http://www.cbpp.org/sites/default/files/atoms/files/12-18-18health.pdf> [https://perma.cc/Z3MM-94BA].

78. See Leighton Ku & Erin Brantley, *Indiana’s Medicaid Work-Requirement Program Is Expected To Cause Tens of Thousands To Lose Coverage*, COMMONWEALTH FUND: TO THE POINT (Oct. 28, 2019), <http://www.commonwealthfund.org/blog/2019/indianas-medicaid-work-requirement-program-expected-cause-tens-thousands-lose-coverage> [https://perma.cc/67FU-UJAJ].

79. JOY MADUBUONWU ET AL., THE COMMONWEALTH FUND WORK REQUIREMENTS IN KENTUCKY MEDICAID: A POLICY IN LIMBO 2 (2019), http://www.commonwealthfund.org/sites/default/files/2019-10/Madubonwu_work_requirements_Kentucky_Medicaid_limbo_ib.pdf [https://perma.cc/8KPG-WVSH].

80. See Sam Gringlas, *South Carolina Gets Green Light To Impose Medicaid Work Requirements*, NPR (Dec. 13, 2019, 5:30 PM), <https://www.npr.org/2019/12/13/787927652/south-carolina-gets-green-light-to-impose-medicaid-work-requirements> [https://perma.cc/J2HR-42FQ].

employment or other qualifying activity.⁸¹ Before it suspended its program,⁸² Indiana was slowly ratcheting up qualifying hours from zero to eighty hours.⁸³

The tying of Medicaid eligibility to employment or the metaphorical “community engagement” is based on several false premises. The first is that Medicaid adults are not working when, in fact, most are employed.⁸⁴ The second is that, rather than work improving health and well-being, health makes it more likely that persons will seek work.⁸⁵ Third, many Medicaid persons live in areas with high unemployment and few jobs or lack the education or credentials to qualify for employment.⁸⁶ Fourth, many Medicaid persons (obviously including those with OUD) have serious medical conditions or disabilities that create significant barriers to employment.⁸⁷ And, perhaps most cruelly, losing or lacking continuity in health insurance jeopardizes health and with it the ability to work.⁸⁸ Relationships between work, health, and food or housing stability are hydraulic; if Medicaid persons have food, health care, or other social supports, they are more likely to work.⁸⁹

More generally, policy shifts even of considerable magnitude and requiring changes in public behavior often scarcely register with those they impact.⁹⁰ Remarkably, nearly half of the Kentucky Medicaid population had never heard of a work requirement—notwithstanding the publicity surrounding Kentucky’s then-Governor Matthew Bevin, his threats to end Medicaid benefits if his work-requirement plan was successfully challenged,⁹¹ not one but two waiver requests

81. See MADUBUONWU ET AL., *supra* note 79, at 2; WAGNER & SCHUBEL, *supra* note 77, at 1; Gringlas, *supra* note 80; Ku & Brantley, *supra* note 78.

82. Press Release, Ind. Family & Soc. Servs. Admin., Pending Resolution of Federal Lawsuit, FSSA Will Temporarily Suspend Gateway to Work Reporting Requirements (Oct. 31, 2019), http://www.in.gov/fssa/files/Gateway_to_Work_suspension_announcement.pdf [https://perma.cc/9EKA-EZ6D].

83. *Learn About Gateway to Work*, IND. FAM. & SOC. SERVS. ADMIN., <http://www.in.gov/fssa/hip/2592.htm> [https://perma.cc/3Q9C-5JU9] (last visited May 1, 2020).

84. MADUBUONWU ET AL., *supra* note 79, at 3; see also RACHEL GARFIELD ET AL., UNDERSTANDING THE INTERSECTION OF MEDICAID AND WORK: WHAT DOES THE DATA SAY? 1 (2019), <http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work-What-Does-the-Data-Say> [https://perma.cc/95LD-3J4Z].

85. See MADUBUNONWU ET AL., *supra* note 79, at 3–4; see also GARFIELD ET AL., *supra* note 84, at 1.

86. GARFIELD ET AL., *supra* note 84, at 2.

87. *Id.* at 8.

88. See *id.*

89. See generally Austin Frakt & Elsa Pearson, *How Cutting Food Stamps Can Add Costs Elsewhere*, N.Y. TIMES (Dec. 31, 2019), <http://www.nytimes.com/2019/12/31/upshot/food-stamps-lower-health-care-costs.html?> [https://perma.cc/9RR8-NY37] (“Food insecurity is linked to worse health outcomes, including poor mental health, high blood pressure and diabetes, with children particularly vulnerable.”).

90. See generally Jessica Greene, *Medicaid Recipient Awareness of Work Requirements: Importance and Challenges*, HEALTH AFF. BLOG (Dec. 10, 2019), <http://www.healthaffairs.org/doi/10.1377/hblog20191205.883142/full/> [https://perma.cc/H4YM-MVM7] (discussing the lack of awareness among those subject to the work requirements and “widespread” confusion among those who are aware).

91. Adam Beam, *Kentucky Governor Says He’ll End Medicaid Benefits for 400,000 if Court Blocks Work Requirements*, CHI. TRIB. (Jan. 16, 2018), <http://www.chicagotribune.com/nation-world/ct-kentucky-governor-medicaid-20180116-story.html> [https://perma.cc/L32Z-SDUA].

and approvals, two district court opinions invalidating the waivers, and coverage of appellate review.⁹²

The hydraulic relationship—the idea that work requirements invert the relationship between work and health, meaning that, rather than being a requirement for health care, work is likely to be a product of good health—explains some of the more progressive plans to provide Medicaid recipients with free job training.⁹³ Indeed, prior to suspending its work requirement, Indiana had first tried to thread the needle between a work requirement and job training by connecting “HIP members with ways to look for work, train for jobs, finish school and volunteer.”⁹⁴ Its “Gateway to Work” program also featured a kinder, gentler rollout that did not require reported hours of work or engagement (and did not cause bad headlines) for the first six months, slowly building to eighty hours per month after July 2020.⁹⁵ Indiana’s Medicaid director reportedly went so far as to vow that no current beneficiaries would lose benefits.⁹⁶

False premises about the substance of work requirements aside, the implementation processes are as worrying. As Rachel Garfield and colleagues noted, “[m]any Medicaid adults do not use computers, the internet or email, which could be a barrier in finding a job and in complying with work reporting requirements.”⁹⁷ It is not only the Medicaid enrollees who face escalating costs; a recent U.S. Government Accountability Office audit reported that Arkansas, Indiana, Kentucky, and New Hampshire spent more than \$129 million on administrative costs, including information technology, in the period between their waiver applications and the end of 2018.⁹⁸

These objections to Medicaid work requirements are, to an extent, theoretical because of the raft of legal challenges they have attracted. District of Columbia Federal District Court Judge James Boasberg enjoined the Kentucky waiver twice, the first time in June 2018⁹⁹ and then, following the Secretary’s reapproval, again in March 2019.¹⁰⁰ Judge Boasberg also struck the Arkansas waiver in March 2019¹⁰¹ and New

92. MADUBUONWU ET AL., *supra* note 79, at 2.

93. See, e.g., Phil Galewitz, *States Try a Gentler Approach to Getting Medicaid Enrollees To Work*, KAISER HEALTH NEWS (Oct. 28, 2019), <http://khn.org/news/states-try-a-gentler-approach-to-getting-medicaid-enrollees-to-work/> [<https://perma.cc/4ADL-6DDL>].

94. *Gateway to Work*, MDWISE, <http://www.mdwise.org/for-members/healthy-indiana-plan/member-information/gateway-to-work> [<https://perma.cc/PK23-3FQW>] (last visited May 1, 2020).

95. *Learn About Gateway to Work*, *supra* note 83.

96. Paige Winfield Cunningham, *Indiana Seeks To Impose Slower, Kinder Work Requirements on Medicaid Recipients*, WASH. POST (Sept. 1, 2019, 8:00 AM), http://www.washingtonpost.com/politics/indiana-seeks-to-impose-slower-kinder-work-requirements-on-medicaid-recipients/2019/08/31/a934c3ce-ca9d-11e9-a4f3-c081a126de70_story.html [<https://perma.cc/N3EP-K3KX>].

97. GARFIELD ET AL., *supra* note 84, at 9.

98. U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-20-149, MEDICAID DEMONSTRATIONS: ACTIONS NEEDED TO ADDRESS WEAKNESSES IN OVERSIGHT OF COSTS TO ADMINISTER WORK REQUIREMENTS 19–20 (2019), <http://www.gao.gov/assets/710/701885.pdf> [<https://perma.cc/3TWY-BB3P>].

99. *Stewart v. Azar*, 313 F. Supp. 3d 237, 274 (D.D.C. 2018) (vacating the Secretary’s approval of Kentucky HEALTH).

100. *Stewart v. Azar*, 366 F. Supp. 3d 125, 156 (D.D.C. 2019). This case was appealed and argued before the U.S. Court of Appeals for the D.C. Circuit in October 2019. *Stewart v. Azar*, No. 19-5095 (D.C. Cir. argued Oct. 11, 2019).

101. *Gresham v. Azar*, 363 F. Supp. 3d 165, 185 (D.D.C. 2019), *aff’d*, 950 F.3d 93 (D.C. Cir. 2020).

Hampshire's in July 2019.¹⁰² A similar case challenging the Indiana waiver was filed in the same court in September 2019.¹⁰³ In all cases, plaintiffs essentially argued that the work-requirement waivers fundamentally altered the design and purpose of Medicaid, while the Secretary neither offered his own estimates of the number of Medicaid persons who would lose coverage nor dealt with the estimates in the record.¹⁰⁴

As Judge Boasberg noted in *Philbrick v. Azar*,¹⁰⁵ the New Hampshire case, in reviewing the prior litigation,

[t]he overriding shortcoming in the [CMS] decisions in those cases was its failure to adequately consider the requirements' effects on Medicaid coverage. Despite conceding that providing medical care to the needy is "Medicaid's core objective," HHS did not "offer its own estimates of coverage loss or grapple with comments in the administrative record projecting that the proposal would lead a substantial number of residents to be disenrolled from Medicaid."¹⁰⁶

The substance of these cases turns on whether, in exercising his discretion, the Secretary had identified the objectives of the Medicaid Act and explained why the approved demonstration promotes them.¹⁰⁷ As to the former, Judge Boasberg found, as he had before, that the core objective of the Medicaid statute was to provide medical assistance to "persons who cannot afford it."¹⁰⁸ As to the latter, "the agency was required to reasonably explain whether New Hampshire's proposed community-engagement requirements would advance or impede that goal. In other words, 'the Secretary needed to consider whether the demonstration project would be likely to cause recipients to *lose* coverage and whether it could cause others to *gain* coverage.'"¹⁰⁹ In a nutshell,

What does the Secretary think about all this? Does he concur with New Hampshire's apparent view that coverage loss is going to be minimal, or does he agree with the commenters that it is likely to be substantial? Are the coverage losses in Arkansas likely to be replicated in New Hampshire? We have no idea, since the approval letter offers no hints. While Defendants may well be correct that HHS does not need to provide a precise numeric estimate of coverage loss, it can hardly be disputed that the agency needs to address the *magnitude* of that loss. That is particularly so where the comments uniformly assert—and the record evidence from similar programs strongly

102. *Philbrick v. Azar*, 397 F. Supp. 3d 11, 33 (D.D.C. 2019).

103. Complaint for Declaratory and Injunctive Relief at 4, *Rose v. Azar*, No. 1:19-cv-02848 (D.D.C. Sept. 23, 2019), http://9kqpw4dcaw91s37kozms5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2019/09/Complaint_Rose-v-Azar-REDACTED.pdf [<https://perma.cc/9NZN-W9P2>].

104. *See, e.g., Gresham*, 363 F. Supp. 3d at 175.

105. 397 F. Supp. 3d 11 (D.D.C. 2019).

106. *Philbrick*, 397 F. Supp. 3d at 15 (citation omitted) (quoting *Gresham*, 363 F. Supp. 3d at 175–76).

107. *See, e.g., id.* at 15–16 (explaining that in each of the work-requirement cases "HHS has fallen short of this fundamental administrative-law requirement").

108. *Id.* at 23; *see also Gresham*, 363 F. Supp. 3d at 176.

109. *Philbrick*, 397 F. Supp. 3d at 23 (quoting *Gresham*, 363 F. Supp. 3d at 177).

suggests—that the loss will be substantial. The Secretary’s “failure to address” this “salient factor” renders his decision arbitrary and capricious.¹¹⁰

In February 2020 the U.S. Court of Appeals for the D.C. Circuit upheld Judge Boasberg’s judgment in the Arkansas case, meaning that any possible resolution of the issue in the administration’s favor will have to await the Supreme Court.¹¹¹ Writing for the court, Judge Sentelle noted, “The statute and the case law demonstrate that the primary objective of Medicaid is to provide access to medical care” but that the Secretary had only addressed the “connected goals” of health care coverage and health outcomes.¹¹² The court noted the data showing how the Arkansas requirements had resulted in “significant coverage loss,”¹¹³ concluding: “In total, the Secretary’s analysis of the substantial and important problem is to note the concerns of others and dismiss those concerns in a handful of conclusory sentences. Nodding to concerns raised by commenters only to dismiss them in a conclusory manner is not a hallmark of reasoned decisionmaking.”¹¹⁴ As a result, the Secretary’s prioritization of “non-statutory objectives to the exclusion of the statutory purpose” rendered his decision arbitrary and capricious.¹¹⁵

Because of these successful legal challenges or program suspensions, the work requirements implemented in Kentucky, New Hampshire, and Indiana have not produced any data from which to judge their impact on otherwise eligible Medicaid persons. However, Arkansas was an exception because the state’s modified “Arkansas Works” program had been up and running for about nine months before its terminal day in court.¹¹⁶ In the first six months, approximately twelve percent of those with Arkansas Medicaid lost coverage yet without significant change in employment or community engagement.¹¹⁷ Before the work requirement, roughly three percent of the Medicaid population was unemployed;¹¹⁸ after implementation, that number rose to just under four percent.¹¹⁹ As with the study of Indiana’s HIP 2.0 program, enrollees were confused about the changes and faced administrative barriers.¹²⁰ A later study found that over eighteen thousand persons lost their health insurance for failing to meet the

110. *Id.* at 24 (quoting *Humane Soc’y of United States v. Zinke*, 865 F.3d 585, 606–07 (D.C. Cir. 2017)).

111. *Stewart v. Azar*, 950 F.3d 93, 104 (D.C. Cir. 2020).

112. *Id.* at 100.

113. *Id.* at 102.

114. *Id.* at 103.

115. *Id.* at 104.

116. See Benjamin Hardy, *Update: Work Requirement Ends Medicaid Coverage for 4,600 More Arkansans in December*, ARK. TIMES (Dec. 17, 2018, 3:08 PM), <http://arktimes.com/arkansas-blog/2018/12/17/update-work-requirement-ends-medicaid-coverage-for-4600-more-arkansans-in-december> [<https://perma.cc/4RH8-UQUG>].

117. Benjamin D. Sommers et al., *Medicaid Work Requirements—Results from the First Year in Arkansas*, 381 NEW ENG. J. MED. 1073, 1079 (2019).

118. *Id.* at 1076–77.

119. *Id.* at 1077.

120. *Id.* at 1079–80.

Arkansas work and reporting requirements, and that was before the full phase-in of the program to all age groups.¹²¹

Based on the Arkansas results and other data, a study projected that approximately 108,000 Kentucky enrollees would lose Medicaid coverage over a two-year period if work requirements were reinstated.¹²² Similar research in New Hampshire estimated that thirty to forty-five percent of expansion persons (as many as twenty-three thousand) would lose their Medicaid coverage if work requirements were implemented.¹²³ One study estimated that between 589,000 and 811,000 people would lose Medicaid coverage after twelve months if the work requirements were implemented in all nine states that have received waivers.¹²⁴

Most research on work requirements and administrative burdens have focused on their impact on enrollees. However, there are also strong negative implications for state economies. For example, one study estimated that hospital uncompensated care would more than double and that their operating margins would drop significantly, particularly in the case of safety net hospitals.¹²⁵ An analysis of the impact of disenrollment caused by work requirements in New Hampshire suggested the loss of between seven and eleven percent of the state's entire budget and, because of the way Medicaid is funded, the "lost federal funding will eclipse reduced state spending by a magnitude of 8.1 to 1."¹²⁶ A broader study estimated that hospitals in work-requirement states would see a decline in Medicaid payments in the \$2.2 to \$3.1 billion range with potentially disastrous consequences for already deeply challenged rural hospitals.¹²⁷

This strong critique of work requirements may seem overblown in the context of those with SUD because, typically, the state plans specifically exempt the medically

121. ROBIN RUDOWITZ ET AL., KAISER FAMILY FOUND., FEBRUARY STATE DATA FOR MEDICAID WORK REQUIREMENTS IN ARKANSAS 4 (2019) [hereinafter RUDOWITZ ET AL., WORK REQUIREMENTS IN ARKANSAS], <http://files.kff.org/attachment/State-Data-for-Medicaid-Work-Requirements-in-Arkansas> [https://perma.cc/GDH9-DSCU].

122. SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, THE POTENTIAL IMPLICATIONS OF WORK REQUIREMENTS FOR THE INSURANCE COVERAGE OF MEDICAID BENEFICIARIES: THE CASE OF KENTUCKY 5 (2018), http://www.commonwealthfund.org/sites/default/files/2018-10/Collins_Kentucky_Medicaid_work_requirements_ib_v2_0.pdf [https://perma.cc/4GZH-BLYG].

123. Leighton Ku & Erin Brantley, *New Hampshire's Medicaid Work Requirements Could Cause More Than 15,000 To Lose Coverage*, COMMONWEALTH FUND: TO THE POINT (May 9, 2019), <http://www.commonwealthfund.org/blog/2019/new-hampshires-medicaid-work-requirements-could-cause-coverage-loss> [https://perma.cc/36ET-LFMZ].

124. Leighton Ku & Erin Brantley, *Medicaid Work Requirements in Nine States Could Cause 600,000 to 800,000 Adults To Lose Medicaid Coverage*, COMMONWEALTH FUND: TO THE POINT (June 21, 2019), <http://www.commonwealthfund.org/blog/2019/medicaid-work-requirements-nine-states-could-cause-600000-800000-adults-lose-coverage> [https://perma.cc/R9UH-E8JS].

125. Randy Haught et al., *The Potential Financial Impact of Medicaid Work Requirement on Kentucky Hospitals*, COMMONWEALTH FUND: TO THE POINT (Nov. 1, 2018), <http://www.commonwealthfund.org/blog/2018/potential-financial-impact-medicaid-work-requirement-kentucky-hospitals> [https://perma.cc/84ZM-39DQ].

126. Sherry A. Glied, *How a Medicaid Work Requirement Could Affect New Hampshire's Economy*, COMMONWEALTH FUND: TO THE POINT (May 9, 2019), <http://www.commonwealthfund.org/blog/2019/how-medicaid-work-requirement-could-affect-new-hampshires-economy> [https://perma.cc/N3KG-AMR6].

127. See RANDY HAUGHT ET AL., HOW WILL MEDICAID WORK REQUIREMENTS AFFECT HOSPITALS' FINANCES? 3, 6–8 (2019), http://www.commonwealthfund.org/sites/default/files/2019-09/Haught_medicaid_work_requirements_hosp_finances_ib_Sept_update.pdf [https://perma.cc/S6Z2-NQR4].

frail or those suffering from SUD.¹²⁸ However, such exemptions tend to be narrow, leading to enrollees falling through the cracks or failing to satisfy the burden of proving the exemption, while there is a history of such requirements disproportionately sanctioning those with disabilities.¹²⁹ A substance use exemption also fails to account for addiction being a “chronic, relapsing disorder characterized by compulsive drug seeking, continued use despite harmful consequences, and long-lasting changes in the brain.”¹³⁰ Those with SUD frequently cycle in and out of treatment, recovery, and relapse.¹³¹ This cycling not only makes keeping a job difficult but ironically also works against exemptions that are based on continual SUD diagnosis or sustained treatment.¹³² According to researchers at the Center on Budget and Policy Priorities,

many people with SUDs won’t be eligible for exemptions. By definition, the “medically frail” exemption includes people with “chronic” SUDs, but that suggests people must have had multiple episodes of substance use or that their illness must have persisted for a long time. Many people with SUDs will not meet this standard.

. . . .

But these [accommodations based on being in treatment] fall short. First, there’s no guarantee that everyone needing treatment will get it. . . .

Second, for those receiving treatment, their particular treatment may not count toward or suffice to meet the work requirement. It’s not clear *which* medical treatments can count toward the monthly hours requirement in Kentucky and New Hampshire or exempt a beneficiary from the work requirement in Indiana and Wisconsin.¹³³

In addition to these substantive requirements for exemptions, attention must be paid to the procedural requirements that increase friction. Examples include the process requirements that have adversely affected enrollments in Indiana (skin-in-the-game requirements)¹³⁴ and Arkansas (work requirements).¹³⁵ Many of those suffering from SUD may be transients who never receive notice of changes to the state’s Medicaid

128. *E.g.*, IND. FAMILY & SOC. SERVS. ADMIN., GATEWAY TO WORK EXEMPTIONS 1, http://www.in.gov/fssa/hip/files/GTW_Exemptions_Portal.pdf [<https://perma.cc/AR9Q-7KLN>].

129. *See Taking Away Medicaid for Not Meeting Work Requirements Harms People with Substance Use Disorders*, CTR. ON BUDGET & POL’Y PRIORITIES, <http://www.cbpp.org/research/health/taking-away-medicare-for-not-meeting-work-requirements-harms-people-with-substance> [<https://perma.cc/4NBF-KLA7>] (last updated Mar. 14, 2019).

130. *See The Science of Drug Use and Addiction: The Basics*, NAT’L INST. ON DRUG ABUSE, <http://www.drugabuse.gov/publications/media-guide/science-drug-use-addiction-basics> [<https://perma.cc/M6U6-W8PS>] (last updated July 2018).

131. *See The Addiction Cycle: Phases of the Chronically Relapsing Disease*, AM. ADDICTION CTRS., <http://americanaddictioncenters.org/the-addiction-cycle> [<https://perma.cc/YR2A-6SF7>] (last updated Nov. 25, 2019).

132. *See, e.g.*, IND. FAMILY & SOC. SERVS. ADMIN., *supra* note 128.

133. *Taking Away Medicaid for Not Meeting Work Requirements Harms People with Substance Use Disorders*, *supra* note 129.

134. *See* Seema Verma & Brian Neale, *Healthy Indiana 2.0 Is Challenging Medicaid Norms*, HEALTH AFF. BLOG (Aug. 29, 2016), <http://www.healthaffairs.org/doi/10.1377/hblog20160829.056228/full> [<https://perma.cc/A9NU-J3SW>].

135. *See* RUDOWITZ ET AL., WORK REQUIREMENTS IN ARKANSAS, *supra* note 121, at 2.

eligibility rules or the necessary qualifying paperwork,¹³⁶ while many will have no or only limited access to the Internet through which they will have to prove their community engagement and continued eligibility. Tellingly, a survey of Medicaid enrollees in Kentucky found that forty-six percent had not heard anything about work requirements and showed patterns of “significant confusion, lack of awareness about the policy, and most adults already satisfying the proposed requirements.”¹³⁷

Although currently blocked by the courts and losing support in some states,¹³⁸ work requirements remain a Trump administration priority, with CMS Administrator Verma recently arguing,

We cannot allow those who prefer the status quo to weaponize the legal system against state innovation. And let’s be clear, it [is] not just state community engagement programs that are under attack. They want to prevent states from adhering to any principles of personal responsibility that could help our beneficiaries successfully transition off public assistance and prepare them to use private coverage.¹³⁹

Such policies are not limited to health care access with the Department of Agriculture seeking to tighten the work requirements for SNAP reportedly jeopardizing assistance for 755,000 recipients.¹⁴⁰

IV. THE SPECTER OF BLOCK GRANTS AND THE LIMITS OF FEDERAL FUNDING

The safety net Medicaid program has been a point of controversy and an ideological battleground long before the current “welfare” versus “insurance” debate that is playing out in the context of work requirements. For conservatives in the central government, Medicaid represents an uncontrollable federal expenditure that is based on an unlimited “pull” from the states.¹⁴¹ As states spend more on their Medicaid programs, so, too, does the disproportionate federal share increase, whether based on the traditional FMAP formula or on the enhanced match provided by Medicaid

136. See SUZANNE WIKLE, CTR. LAW & SOC. POLICY, *MEDICAID WORKS: NO WORK REQUIREMENT NECESSARY* 3, 6 (2018), <http://www.clasp.org/sites/default/files/Medicaid%20Works-No%20Work%20Requirement%20Necessary%20Updated%20December%202018%20final.pdf> [https://perma.cc/3CWC-6TH3].

137. MADUBUONWU ET AL., *supra* note 79, at 5.

138. See generally Nicolas P. Terry, *Are Work Requirements Sinking as Arizona and Indiana Abandon Ship?*, BILL OF HEALTH (Nov. 13, 2019), <http://blog.petrieflom.law.harvard.edu/2019/11/13/are-work-requirements-sinking-as-arizona-and-indiana-abandon-ship> [https://perma.cc/3SW6-N6H5]. Arizona, Indiana, and Montana have recently delayed or cancelled their programs, while a gubernatorial change in Kentucky and the Democratic Party’s takeover of the legislature in Virginia may lead to policy reversals in those two states. *Id.*

139. Press Release, Ctrs. for Medicare & Medicaid Servs., CMS Administrator Seema Verma’s Speech to the National Association of Medicaid Directors in Washington, D.C. (Nov. 12, 2019), <http://www.cms.gov/newsroom/press-releases/cms-administrator-seema-vermas-speech-national-association-medicare-directors-washington-dc> [https://perma.cc/UC5T-C59F].

140. Allan Smith, *Trump Administration Moves To Impose Stricter Work Requirements for Food Stamps*, NBC NEWS (Dec. 20, 2018, 9:44 AM), <http://www.nbcnews.com/politics/politics-news/trump-administration-moves-impose-stricter-work-requirements-food-stamps-n950271> [https://perma.cc/9XR9-7G49].

141. See Rachana Pradhan & Dan Diamond, *Trump Wants To Bypass Congress on Medicaid Plan*, POLITICO (Jan. 11, 2019, 5:14 PM), <http://www.politico.com/story/2019/01/11/trump-bypass-congress-medicare-plan-1078885> [https://perma.cc/VCX5-MTQL].

expansion.¹⁴² Federal fiscal hawks are powerless while the existing funding mechanism is in place. States also have issues with the program. While many states disingenuously object to Medicaid expansion based on fiscal rather than political concerns, state governments are correct that Medicaid's enrollment and coverage rules require levels of state spending that are at the mercy of population shifts; cyclical economic conditions such as recessions that increase unemployment and, as result, the number of Medicaid eligibles; and health care inflation.¹⁴³

During the repeal-and-replace debates of 2017, much of the congressional criticism reflected the then-unpopularity of the ACA's individual marketplace reforms. However, the House, under the leadership of then-House Speaker Paul Ryan, was even more interested in converting Medicaid from open-ended funding to a block grant program.¹⁴⁴ The federal government would provide each state with a fixed sum with some inflation adjustments and leave it up to the states to determine eligibility and services.¹⁴⁵ With repeal-and-replace off the table following the 2018 midterm elections, the Trump administration turned its attention to encouraging states to apply for a waiver permitting conversion to a block grant.¹⁴⁶ Utah's recently approved waiver that allows for enrollment to be closed in some circumstances provided a bellwether for block grant applications.¹⁴⁷ The first explicit application for a block grant conversion was from Tennessee, a nonexpansion state that was seeking to replace some of its traditional Medicaid program with a block grant.¹⁴⁸ As noted by Sara Rosenbaum and Alexander Somodevilla, if approved, "Medicaid would be reduced to a federal revenue pool untethered from basic insurance safeguards."¹⁴⁹

The link between Medicaid and reducing the opioid overdose epidemic is fundamental to the obvious objection that Rachel Sachs and Nicole Huberfeld raised

142. See RUDOWITZ ET AL., 10 THINGS TO KNOW ABOUT MEDICAID, *supra* note 24, at 8 & fig.8.

143. See LAURA SNYDER & ROBIN RUDOWITZ, TRENDS IN STATE MEDICAID PROGRAMS: LOOKING BACK AND LOOKING AHEAD 4 (2016), <http://files.kff.org/attachment/Issue-Brief-Trends-in-State-Medicaid-Programs> [<https://perma.cc/4XQM-QZHQ>] (discussing states' responses to legal, demographic, and economic changes over time in the context of Medicaid spending).

144. See Shefali Luthra, *Everything You Need To Know About BlockGrants—The Heart of GOP's Medicaid Plans*, KAISER HEALTH NEWS (Jan. 24, 2017), <http://khn.org/news/block-grants-medicaid-faq/> [<https://perma.cc/8C6B-24C9>] (describing Medicaid block grants as a "centerpiece" of health proposals supported by then-House Speaker Ryan).

145. *Id.*

146. See Letter from Frank Pallone, Jr., Chairman, House Comm. on Energy & Commerce, to Alex M. Azar, Sec'y, U.S. Dep't of Health & Human Servs. (June 27, 2019), <http://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/HHS.2019.6.26..pdf> [<https://perma.cc/U44E-LW47>].

147. See generally Cindy Mann, *One Step Forward, Two Steps Back: Utah's Medicaid Expansion*, COMMONWEALTH FUND: TO THE POINT (Oct. 23, 2019), <http://www.commonwealthfund.org/blog/2019/one-step-forward-two-steps-back-utahs-medicaid-expansion> [<https://perma.cc/H5D4-2MDP>] (discussing Utah's use of an enrollment cap as the state may "close enrollment for the newly covered adult group at any time 'should projected costs for the group exceed annual state appropriations'").

148. COMM'R TENN. DEP'T FIN. & ADMIN., NOTICE OF CHANGE IN TENNCARE II DEMONSTRATION: AMENDMENT 42, at 1 (2019), <http://www.tn.gov/content/dam/tn/tenncare/documents2/Amendment42ComprehensiveNotice.pdf> [<https://perma.cc/T8H5-775S>].

149. Sara Rosenbaum & Alexander Somodevilla, *Looking Inside Tennessee's Block Grant Proposal*, HEALTH AFF. BLOG (Oct. 4, 2019), <http://www.healthaffairs.org/doi/10.1377/hblog20191002.734156/full> [<https://perma.cc/RZ72-SJ56>].

that “capped spending would very likely involve disenrollment and other cost-cutting measures that endanger the lives of the most vulnerable patients.”¹⁵⁰ Further, a capped program would probably reduce or eliminate expensive programs such as behavioral health services and shrink the Medicaid population at a time when the exigencies of the opioid crisis require the opposite.¹⁵¹ Notwithstanding, the Trump administration has made it clear that it will pursue a block grant model, albeit one rebranded as a “Health Adult Opportunity” (HAO), in a January 2020 letter to State Medicaid Directors.¹⁵² In an opinion piece published in the *Washington Post* a few days later, CMS Administrator Verma asserted, “Fearmongering notwithstanding, HAO does not cut Medicaid funding.”¹⁵³ Her statement was broadly criticized on social media.¹⁵⁴ Further, Professor Nicholas Bagley characterized the proposal as an attempt “to transform Medicaid from an entitlement program covering all the poor into a selective welfare program funded by fixed and limited block grants—a shift that, over time, could starve the program of funding,” arguing that legal challenges similar to those in the work requirements cases were inevitable.¹⁵⁵

There is another important link between block grants and opioids: the mechanics of how the federal government has been funding the states in an effort to tackle the opioid crisis. A series of federal statutes dating from the Comprehensive Addiction and Recovery Act of 2016¹⁵⁶ and the 21st Century Cures Act of the same year¹⁵⁷ to the SUPPORT Act of 2018¹⁵⁸ have favored temporary grants to states as their preferred funding mechanism in contrast to more open-ended funding. Some of the funding has been direct, as in the case of modest increases in Medicaid funding.¹⁵⁹ However, most

150. Rachel Sachs & Nicole Huberfeld, *The Problematic Law and Policy of Medicaid Block Grants*, HEALTH AFF. BLOG (July 24, 2019), <http://www.healthaffairs.org/doi/10.1377/hblog20190722.62519/full> [<https://perma.cc/D2E7-YCKL>].

151. *See id.*

152. Letter from Calder Lynch, Dir., Ctrs. for Medicare and Medicaid Servs., to State Medicaid Directors (Jan. 30, 2020), <http://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf> [<https://perma.cc/U799-GJWA>].

153. Seema Verma, Opinion, *No, the Trump Administration Is Not Cutting Medicaid*, WASH. POST (Feb. 6, 2020, 1:38 PM), <http://www.washingtonpost.com/opinions/2020/02/06/seema-verma-trump-administration-not-cutting-medicaid/> [<https://perma.cc/YEA5-PPHY>].

154. *E.g.*, Jake Johnson, “Blatant Lie”: *Seema Verma Claims Trump Not Cutting Medicaid as He Pushes Plan Doing Just That*, COMMON DREAMS (Feb. 7, 2020), <http://www.commondreams.org/news/2020/02/07/blatant-lie-seema-verma-claims-trump-not-cutting-medicaid-he-pushes-plan-doing-just> [<https://perma.cc/HR8F-LPT7>] (compilation of sample responses).

155. Nicholas Bagley, *The Trump Administration’s New Attempt To Gut Medicaid*, WASH. POST (Feb. 6, 2020, 4:25 PM), <http://www.washingtonpost.com/outlook/2020/02/06/trump-administrations-new-attempt-gut-medicaid/> [<https://perma.cc/Y9XD-XKAS>].

156. Comprehensive Addiction and Recovery Act of 2016, Pub. L. No. 114-198, 103 Stat. 695 (2016).

157. 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1033 (2016).

158. Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, Pub. L. No. 115-271, 132 Stat. 3894 (2018).

159. *E.g.*, SUPPORT Act § 5061, 132 Stat. at 3976; Comprehensive Addiction and Recovery Act of 2016 § 707, 103 Stat. at 754; *see also* Cindy Mann & Jocelyn Guyer, *Medicaid Provisions in the SUPPORT Act: An Important Step Forward in the Opioid Epidemic, but the Road Ahead Is Long*, COMMONWEALTH FUND: TO THE POINT (Nov. 13, 2018), <http://www.commonwealthfund.org/blog/2018/medicaid-provisions-support-act-important-step-forward-opioid-epidemic-road-ahead-long> [<https://perma.cc/648S-RZYF>] (discussing additional enhanced Medicaid funding for SUD “health homes”).

of the funds HHS agencies dispensed through grants, such as the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration, and the Centers for Disease Control, have operated more like short-term block grants. For example, SAMHSA distributed \$2.3 billion to the states by the end of 2019.¹⁶⁰

Much of the attention paid to this federal largesse has been on the adequacy of the funding with the total federal payout of \$9 billion through 2019,¹⁶¹ falling far short of the estimated costs of the epidemic. For example, a 2018 estimate from Altarum suggested \$1 trillion of costs incurred from 2001 to 2017 with a further toll of \$500 billion by 2020.¹⁶² A 2019 study by the Society of Actuaries estimated the total economic burden from 2015 to 2018 at \$631 billion, including additional health care services, premature mortality, criminal justice interventions, and child as well as family assistance programs.¹⁶³ The federal payouts also fell far short of alternate plans such as the one that Senator Elizabeth Warren and Representative Elijah Cummings put forward in 2018 for \$100 billion over ten years with a disproportionate amount of funding going to states, cities, and counties that had been hit the hardest.¹⁶⁴

In addition to the relatively small amounts that the federal government committed, questions also have arisen as to the grant (or block-like grant) approach to the funding. Grants tend to come with relatively short spending horizons that serve as disincentives from building infrastructure or workforce to support, for example, expanded community-based care amidst uncertainty over whether the funding will be renewed.¹⁶⁵ They also tend not to be good sources for programs with distinctly long-term needs such as addressing the social determinants of health.¹⁶⁶

160. Press Release, U.S. Dep't Health & Human Servs., State Opioid Response Grants by State (Sept. 4, 2019), <http://www.hhs.gov/about/news/2019/09/04/state-opioid-response-grants-by-state.html> [https://perma.cc/U7Y6-5NZ8].

161. Press Release, U.S. Dep't Health & Human Servs., Trump Administration Announces \$1.8 Billion in Funding to States To Continue Combating Opioid Crisis (Sept. 4, 2019), <http://www.hhs.gov/about/news/2019/09/04/trump-administration-announces-1-8-billion-funding-states-combating-opioid.html> [https://perma.cc/TX79-QKTH].

162. *Economic Toll of Opioid Crisis in U.S. Exceeded \$1 Trillion Since 2001*, ALTARUM (Feb. 13, 2018), <http://altarum.org/news/economic-toll-opioid-crisis-us-exceeded-1-trillion-2001> [https://perma.cc/Q6JB-65NR].

163. STODDARD DAVENPORT ET AL., SOC'Y OF ACTUARIES, ECONOMIC IMPACT OF NON-MEDICAL OPIOID USE IN THE UNITED STATES 4, 5 fig.1 (2019), <http://www.soa.org/globalassets/assets/files/resources/research-report/2019/econ-impact-non-medical-opioid-use.pdf> [https://perma.cc/GDU2-4S7S].

164. Rachel Roubein, *Warren, Cummings Seek \$100B To Fight Opioid Epidemic*, HILL (Apr. 18, 2018, 2:20 PM), <http://thehill.com/business-a-lobbying/383787-warren-cummings-seek-100b-to-fight-opioid-epidemic> [https://perma.cc/JLK6-FXKB].

165. See, e.g., Abby Goodnough, *States Are Making Progress on Opioids. Now the Money That's Helping Them May Dry Up*, N.Y. TIMES (July 16, 2019), <http://www.nytimes.com/2019/07/16/health/opioids-grants-treatment-addiction.html> [https://perma.cc/47SY-M3PU].

166. See Nicolas Terry, *From Health Policy to Stigma and Back Again: The Feedback Loop Perpetuating the Opioids Crisis*, 2019 UTAH L. REV. 785, 792.

CONCLUSION

This Essay concentrated on access to health care for those suffering with OUD. However, it must be remembered that is only the beginning of the story. Increasing access to care does not necessarily translate into similar gains in treatment because of barriers such as the lack of treatment centers, stigma, workforce inadequacies, and transportation.¹⁶⁷ Access, however, remains the initial barrier.

One of the most shocking statistics related to the opioid overdose epidemic is that only thirty-four percent of adults with OUD received some type of treatment or recovery service.¹⁶⁸ In contrast, Medicaid provides—or should provide—real hope for a substantial percentage of the population suffering with OUD. Medicaid's central position in the federal and state governments' reactions to the opioid overdose epidemic cannot be overstated. Neither can the sense of disappointment that its potential has not been fully executed. Medicaid expansion has proven particularly beneficial for vulnerable populations such as those with SUDs. A state's refusal to expand Medicaid is not an example of fiscal responsibility but the punishment of the state's poor and sick.

At the federal level, a schizophrenic policy seems to have taken hold. Clearly the administration sees and values Medicaid as one of the key pillars of its policy to ameliorate the opioid overdose epidemic. Yet, at the same time it encourages politically motivated, existential attacks on Medicaid itself by approving work-requirement waivers and maybe soon by converting to block grants. Unlocking the solutions to the opioid overdose epidemic has proven extremely difficult. Medicaid and Medicaid expansion have been a few of the identified keys with the latter being positively associated with a decrease in SUD-related deaths.¹⁶⁹ Those suffering with SUD face immense stigma. Taking away their health care because they cannot work or find work or because they are not reporting the work they are actually performing is additionally stigmatizing, as is conditioning their enrollment on proving their "addiction." Any approved block grants are likely to attract the same kind of legal skepticism as work requirements. As Judge Boasberg noted in reviewing serial work-requirement waiver approvals, "we have all seen this movie before."¹⁷⁰ Hopefully, with the data emerging on the effect of work requirements on enrollments and the consistently successful legal challenges, Arizona will be only the first of the states that had been granted a work-requirement waiver to give up on this foolish and cruel adventure.¹⁷¹

167. See generally Mark Olsson et al., *Impact of Medicaid Expansion on Coverage and Treatment of Low-Income Adults with Substance Use Disorders*, 37 HEALTH AFF. 1208 (2018) ("Despite the development of effective treatments for common substance use disorders, only a small fraction of US adults with these conditions receives treatment each year." (footnotes omitted)).

168. ORGERA & TOLBERT, *supra* note 10, at 4.

169. Julia Thornton Snider et al., *Association Between State Medicaid Eligibility Thresholds and Deaths Due to Substance Use Disorders*, JAMA NETWORK OPEN, Apr. 2019, at 1, 5. <http://jamanetwork.com/journals/jamanetworkopen/fullarticle/2731689> [<https://perma.cc/8CWL-NP5N>].

170. *Philbrick v. Azar*, 397 F. Supp. 3d 11, 16 (D.D.C. 2019).

171. Letter from Jami Snyder, Dir., Az. Health Care Cost Containment Sys., to Calder Lynch, Deputy Adm'r & Acting Dir., Ctr. for Medicaid & CHIP Servs. (Oct. 17, 2019), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-postponement-ltr-ahcccs-works-10172019.pdf> [<https://perma.cc/N2A3-V4PX>].

Of course, there may be worse days ahead. In *Texas v. United States*,¹⁷² Judge Reed O'Connor ruled that the ACA was unconstitutional since the individual mandate had been zeroed out.¹⁷³ Subsequently the U.S. Court of Appeals for the Fifth Circuit agreed that the congressional taxing power could no longer save the individual mandate¹⁷⁴ and remanded the question of severability, “directing the district court to employ a finer-toothed comb on remand and conduct a more searching inquiry into which provisions of the ACA Congress intended to be inseverable from the individual mandate.”¹⁷⁵ Although the Supreme Court has granted review,¹⁷⁶ its decision on the future of the ACA will almost certainly postdate the 2020 elections.

If the ACA falls, some fifty-four million Americans with preexisting conditions would find themselves uninsurable in the individual marketplace without the ACA's prohibition on medical underwriting.¹⁷⁷ It seems highly likely that those suffering with OUD or other behavioral health issues would make up a substantial proportion of the cohort with preexisting conditions. Further, without the ACA and its compulsion to cover essential health benefits,¹⁷⁸ it is likely that many insurers would simply drop coverage of behavioral health services. Even worse, judicial condemnation of the ACA would bring a halt to Medicaid expansion and the hope that brings to many of those who live with SUDs.

172. 340 F. Supp. 3d 579 (N.D. Tex. 2018), *aff'd in part, vacated in part*, 945 F.3d 355 (5th Cir. 2019), *cert. granted sub nom.* *Texas v. California*, No. 19-1019, 2020 WL 981805 (U.S. Mar. 2, 2020).

173. *Texas v. United States*, 340 F. Supp. 3d at 619.

174. *Texas v. United States*, 945 F.3d at 390. After the Fifth Circuit's decision, the democratic states defending the ACA requested the Supreme Court hear the case on an expedited basis on January 3, 2020. Petition for a Writ of Certiorari, *California v. Texas*, No. 19-840 (U.S. Jan. 3, 2020), 2020 WL 58603.

175. *Texas v. United States*, 945 F.3d at 402.

176. *Texas v. California*, 2020 WL 981805.

177. See Gary Claxton et al., *Pre-Existing Condition Prevalence for Individuals and Families*, KAISER FAM. FOUND. (Oct. 4, 2019), <http://www.kff.org/health-reform/issue-brief/pre-existing-condition-prevalence-for-individuals-and-families/> [<https://perma.cc/UYF2-XGAX>].

178. See 42 U.S.C. § 18022(a)-(b) (2018).