No. 11-681

IN THE

Supreme Court of the United States

PAMELA HARRIS, *et al.*,

Petitioners,

v.

PAT QUINN, GOVERNOR OF ILLINOIS, *et al.*,

Respondents.

On Writ of Certiorari
to the United States Court of Appeals
for the Seventh Circuit

BRIEF FOR *AMICUS CURIAE* THE PARAPROFESSIONAL HEALTHCARE INSTITUTE (PHI) IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICUS*[1]

Founded in 1992, the Paraprofessional Healthcare Institute (PHI) is the nation's leading authority on the direct-care workforce. With offices in New York, Michigan, and Washington, D.C., PHI fosters dignity, respect, and independence—for all who receive care and all who provide it.

PHI works with employers, consumers, labor advocates, and government officials to develop recruitment, training, supervision, and person-centered caregiving practices and policies.

PHI is the nation's primary source for direct-care workforce news and analysis—anchored at www.PHInational.org. PHI's State Data Center online resource (http://phinational.org/policy/states/) provides up-to-date profiles of the direct-care workforce in all 50 states, including key workforce statistics, information on state initiatives to improve these jobs, and state-by-state information on training requirements.

SUMMARY OF ARGUMENT

This Court has long recognized that a state's choice about how to handle the provision of public services warrants substantial deference. In

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[1] Letters from the parties consenting generally to the filing of briefs *amicus curiae* are on file with the Court. Pursuant to Rule 37.6, counsel for *amicus* states that no counsel for a party authored this brief in whole or in part, and that no person other than *amicus* or its counsel made a monetary contribution to the preparation or submission of this brief.

particular, it has accorded states wide latitude in deciding how to manage the workforce that provides those services.

Petitioners characterize themselves as individuals who "participate" in a "public aid program," Petr. Br. 14, but that description is misleading. Petitioners are not mere private citizens receiving a state subsidy to pursue their private goals. Rather, they are part of a workforce paid by the State of Illinois to carry out a vital state function: providing assistance to disabled individuals through the Medicaid program. Illinois has determined that it can often best provide that assistance through home-based programs in which it delegates significant decisionmaking authority to beneficiaries. But it can achieve that goal only if it can develop a workforce large enough, stable enough, and skilled enough to meet its overall program needs. Illinois had a strong empirical basis for concluding that offering collective bargaining to the publicly funded workforce that implements its Medicaid program can contribute to developing the necessary workforce.

1. Like many states, Illinois is innovating how it provides state-funded, long-term care. Both to enhance the dignity and autonomy of Medicaid beneficiaries and to provide cost-effective service, Illinois has chosen to provide care to many Medicaid beneficiaries in their homes rather than in institutions, and to delegate to those beneficiaries a degree of control over how that care is provided. Yet the state also retains significant control over the employment terms of workers who provide this care. Petitioners wrongly imply that a state's role must be all or nothing. To the contrary: A state does not

forfeit its preexisting authority to manage its internal operations by adopting policies that improve that operation.

2. If anything, consumer-directed home-based care reinforces the need for active state involvement in managing the provider workforce. In the face of a disorganized market, states face an accelerating crisis in finding and retaining homecare workers. The nature of the work makes it hard to attract personnel in the first place, and those who do enter the field turn over at an alarming rate. Half of all beneficiaries change providers each year.

Left unremedied, this turnover poses significant costs for both the state providing care and the beneficiaries receiving it. And the state cannot rely on beneficiaries or individual providers to solve the problem. Neither individual low-income Medicaid beneficiaries nor individual low-income aides have the expertise, the resources, or the incentives to address labor market imperfections.

3. Though states could choose to attack the labor supply issue unilaterally, many states, including Illinois, have decided instead that cooperative labor-management solutions are more promising. Illinois reasonably relied on longstanding experience to conclude that unionization could enable the state to capture the benefits of a consumer-directed model while also retaining many benefits of a more structured work relationship.

ARGUMENT

I. States Have A Strong Interest In Managing How They Provide Long-Term Homecare To Disabled And Elderly Residents.

Petitioners challenge one aspect of a state-designed, state-managed, and state-funded Medicaid program: the state's decision to offer collective bargaining to the workers who implement that program. But the state's decision did not arise in a vacuum.

For decades, states have provided care to low-income citizens who are elderly or disabled through Medicaid. Medicaid allows states substantial leeway in designing and managing their programs, so that states can take account of their distinctive needs and resources. Not surprisingly, state Medicaid programs illustrate Justice Brandeis's famous observation that "[i]t is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments." *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting). As the Federal Government explains, "[w]hat state Medicaid programs have most in common is that they are all different."[2]

To understand why Illinois acted reasonably in offering collective bargaining to line-level Medicaid-

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[2] Janet O'Keeffe et al., U.S. Dep't of Health & Human Servs., *Understanding Medicaid Home and Community Services: A Primer* 16 (2010) [hereinafter *Medicaid Primer*], *available at* http://tinyurl.com/PHI-primer.

funded personnel requires understanding why states have moved to consumer-directed, home-based care for low-income citizens who otherwise face difficulties living on their own. States have found that such care not only protects citizens' dignity and autonomy, but also that it is cost effective.

A. States Increasingly Provide Long-Term Care In Beneficiaries' Homes To Reduce Isolation And Save Resources.

For persons who require Medicaid-funded long-term care, many states are shifting away from institutional care, which can isolate individuals from their families and communities, and towards home-based care.

Federal law has contributed to this shift. In 1983, Congress took a first step by waiving the pre-existing requirement that Medicaid-funded care be provided in institutions.[3] It later formally authorized states to offer "home- and community-based services" as part of state Medicaid programs.[4] Subsequent legislation created additional incentives to move toward home-based care. For example, the Americans with Disabilities Act of 1990, as interpreted by this Court in *Olmstead v. L.C.*, 527 U.S. 581 (1999), gave persons with disabilities a

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[3] Omnibus Reconciliation Act of 1981, Pub. L. No. 97-35, §§ 2175-2176, 95 Stat. 357, 809-12 (codified as amended at 42 U.S.C. § 1396n).

[4] Deficit Reduction Act of 2005, Pub. L. No. 109-171, §§ 6085-6086, 120 Stat. 4, 121-127 (codified as amended at 42 U.S.C. § 1396n).

statutory right to be placed whenever feasible in community settings rather than institutions.[5] Then the Deficit Reduction Act of 2005 provided funds for Money Follows the Person demonstrations that pay states an enhanced federal matching rate for each person transitioned from an institution to the community.[6] And the Patient Protection and Affordable Care Act of 2010 provided new options for states to increase the availability of home- and community-based services.[7] All states now offer some form of home-based care.[8]

Beyond the federal incentives, states have strong independent reasons to offer home-based care. Providing care in a beneficiary's own home maximizes autonomy and dignity. Public opinion studies have consistently shown that roughly 85% of Americans would prefer to receive long-term care at home.[9] Indeed, in one sample of seriously ill

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[5] The *Olmstead* Court interpreted the Americans with Disabilities Act of 1990, 42 U.S.C. § 12132, along with its implementing regulation, 28 C.F.R. § 35.130(d).

[6] Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6071, 120 Stat. 4, 102-10.

[7] *See generally* Carol V. O'Shaughnessy, Nat'l Health Policy Forum, *Medicaid Home- and Community-Based Services Programs Enacted by the ACA: Expanding Opportunities One Step at a Time* (2013), *available at* http://tinyurl.com/PHI-ACA.

[8] Medicaid Primer, *supra*, at 22.

[9] *See, e.g.*, AARP, *Beyond 50.05 Survey* 9 (2005), *available at* http://tinyurl.com/PHI-AARP1 (finding that 84% of persons 50 or older want to stay in their own home for "as long as possible"); AARP, *Home and Community Preferences of the 45+ Population* 3 (2010), *available at* http://tinyurl.com/PHI-AARP2

hospitalized adults, 30% reported that they would "rather die" than live permanently in a nursing home; a further 37% reported that they were "unwilling" to do so.[10]

The literature is filled with examples that explain this preference. Consider Walter Brown. Mr. Brown suffered a stroke in 2007 and was placed in a nursing home. "It was like being in jail," Mr. Brown said. "In the nursing home you've got to do what they say when they say it, go to bed when they tell you, eat what they want you to eat." But when the state provided the opportunity to return home, it made him "more confident in [him]self," and "in the future."[11]

Not only does home-based care promote autonomy and dignity, but it is cost effective as well. The cost of 24/7 care in a nursing facility can be "astronomical."[12] State studies consistently find far lower average costs per individual in home- and community-based settings.[13] A 2011 study estimated

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(finding that 86% of persons 45 or older agreed with the statement that they would "really like" to "stay in [their] current residence for as long as possible").

[10] T.J. Mattimore et al., *Surrogate and Physician Understanding of Patients' Preferences for Living Permanently in a Nursing Home*, 45 J. Am. Geriatrics Soc'y 818 (1997).

[11] John Leland, *Helping Elderly Leave Nursing Homes for a Home*, N.Y. Times, Sept. 19, 2009, at A10, *available at* http://tinyurl.com/PHI-NYT.

[12] Nat'l Consumer Voice for Quality Long-Term Care, *Consumer Perspectives on Quality Home Care* 16 (2012), *available at* http://tinyurl.com/PHI-NCV.

[13] Wendy Fox-Grage & Jenna Walls, AARP Pub. Policy Inst., *State Studies Find Home and Community-Based Services*

the annual cost saving of a move from institutional care to home- and community-based settings was $57,338 per person.[14]

B. States Increasingly Grant Beneficiaries Some Choice Over State-Funded Service Providers.

More recently, states have modified their programs in a second significant respect: offering consumer- or participant-directed services as an alternative to the traditional model in which agencies set the parameters of service delivery. Consumer direction began with the Independent Living movement in the 1970s when "individuals with disabilities demanded greater control over the services they receive in the community."[15] Today, almost every state has added a beneficiary-directed component to its Medicaid program.[16]

States can delegate a variety of decisions to beneficiaries. A commonly delegated choice involves selecting the direct-service provider. In Illinois, for example, beneficiaries are given wide latitude within

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to Be Cost-Effective (2013), *available at* http://tinyurl.com/PHI-Fox-Grage.

[14] Charlene Harrington et al., *Do Medicaid Home and Community Based Service Waivers Save Money?*, 30 Home Health Care Servs Q. 198, 198 (2011).

[15] Henry Claypool & Molly O'Malley, Kaiser Comm'n on Medicaid & the Uninsured, *Consumer Direction of Personal Assistance Services in Medicaid: A Review of Four State Programs* 1 (2008), *available at* http://tinyurl.com/PHI-Claypool.

[16] Medicaid Primer, *supra*, at 177.

state-set limits to choose the individual who comes to their home to provide support and services. Pet. App. 3a.

Consumer choice furthers patients' autonomy and dignity in obvious ways. For those individuals who have strong feelings about who should enter their home and who should provide services that often intrude on personal privacy, "[p]articipant direction has been demonstrated to promote positive outcomes for individuals and their families, improve participant satisfaction, and increase access to needed services."[17]

As with home-based care more generally, the literature supports this common-sense conclusion. Consider Calvin Dodson. Dodson was blinded by an automobile accident and also required dialysis three times per week. Under an agency model, he "got a different worker every week." He was "always having to explain everything from the beginning, every time." And the workers the agency sent "never wanted to do the jobs [he] needed them to do."[18] By allowing beneficiaries to hire their own providers, beneficiaries may be able to secure greater continuity of care and better opportunities to select and help train a compatible personal care aide.

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[17] Medicaid Primer, *supra*, at 177.

[18] Robert Wood Johnson Found., *Choosing Independence: An Overview of the Cash & Counseling Model of Self-Directed Personal Assistance Services* 40-41 (2006), *available at* http://tinyurl.com/PHI-RWJF.

Consumer-directed care can also be cost effective. For example, beneficiaries may be in a better position than the state to determine which potential provider is the best match for them. When states share with program beneficiaries the process of selecting and assigning providers, they can reduce the number of poor matches that result in turnover and less effective care.

But while states delegate some decisions to beneficiaries, they retain significant control over many important terms of employment. In Illinois, the state continues to set job duties, wage rates, and worker qualifications. And it continues to pay workers directly. Pet. App. 3a.

And while recent innovations have decentralized the locations at which Medicaid services are provided and devolved aspects of the selection process to beneficiaries, the day-to-day work remains quite similar to the work previously provided within nursing facilities.[19] Like their predecessors in institutional settings, the personal care aides whose work is at issue in this case assist with essential daily supports and services, such as eating, dressing, using the bathroom, managing prescription medications, and ambulation.[20] At the same time, now that the beneficiaries remain at home, aides assist with running errands, traveling to doctor appointments, and better enabling an active family

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[19] Dorie Seavey, *Caregivers on the Front Line: Building a Better Direct-Care Workforce*, Generations, Winter 2010-11, at 27-28, *available at* http://tinyurl.com/PHI-Seavey1.

[20] *Id.* at 28.

and community life—for instance, by helping a beneficiary to attend religious services or social gatherings. Particularly for elderly beneficiaries, social supports help ensure that their cognitive states do not deteriorate from isolation.[21]

C. Contrary To Petitioners' Argument, A State's Decision To Innovate In How It Provides Medicaid Does Not Deprive The State Of Its Managerial Role.

At its core, petitioners' argument is that if the state allows Medicaid beneficiaries to stay in their homes and play a role in choosing who provides Medicaid-funded personal services, the state's role and interest in these programs becomes "quite limited." Petr. Br. 7.

Not so. As a descriptive matter, states like Illinois retain immense control over most aspects of how they provide services under Medicaid. They decide eligibility for services. They decide which services to provide. They decide the minimum qualifications required for workers providing those services. And they decide those workers' pay rates and hours. Pet. App. 3a.

It makes no sense to suggest that a state has somehow forfeited its ongoing ability to "'manage [its] internal operation,'" *Engquist v. Or. Dep't of Agric.*, 553 U.S. 591, 598 (2008) (alteration in original) (citation omitted), by adopting policies that improve that operation. The very reason states decided to

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[21] *Id.*

offer services at beneficiaries' homes and to share some decisionmaking authority with beneficiaries is because those innovations further vital *state* interests in dignity and efficiency—not because the state is uninterested in how a huge portion of its budget gets spent.

To be sure, there is a market for homecare services where the state's role and interests are indeed "quite limited." That is the private market in which individuals seeking services pay for those services themselves and negotiate the terms of employment within the private labor market's broad constraints. Petitioners were free to offer their services in that market if they preferred the terms and conditions available there. Instead, they chose a state paycheck. It is petitioners, and not the state, who are seeking to have it both ways. They want the state to pay them without their being treated as state providers and without their needing to conform to the personnel system that the state has established to accomplish its programmatic goals. But their preferences cannot override the state's right to run a publicly funded, highly regulated program in the manner that the state reasonably believes allows that program to best accomplish its objectives.

II. States Face Significant Labor Market Problems In Building And Stabilizing The Homecare Workforce Their Medicaid Programs Demand.

The success of a state's transition to a home-based, consumer-directed Medicaid program depends on the availability of a pool of skilled and dependable workers. Yet states face an accelerating crisis in

finding and keeping such workers. That crisis has several dimensions. But one thing is clear: given the structure of consumer-directed homecare, the state must necessarily be an active participant in recruiting and retaining workers if it wishes to provide such services to all who might qualify and benefit. Individual Medicaid beneficiaries have neither the ability nor the incentive to build that workforce.

A. States Confront A Severe And Worsening Shortage Of Homecare Workers.

The Institute of Medicine has recognized that the need for in-home providers "is beginning to reach a crisis stage."[22] The source of the crisis lies in both an increased demand for homecare services and a static or decreasing supply of workers.

1. With respect to demand, elderly individuals and persons with disabilities are living longer than ever before and increasingly electing to receive care in their homes. As the baby boom generation ages, this demand will grow.[23] Indeed, the Department of Labor projects a need for 71% more personal care aides and 69% more home health aides between 2010

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[22] Comm. on the Future Health Care Workforce for Older Ams., Inst. of Med. of the Nat'l Acads., *Retooling for an Aging America: Building the Health Care Workforce* 199 (2008) [hereinafter Inst. of Med.], *available at* http://tinyurl.com/PHI-InstofMed.

[23] Comm'n on Long-Term Care, U.S. Senate, *Report to the Congress* 5 (Sept. 30, 2013), *available at* http://tinyurl.com/PHI-CLTC.

and 2020. In no other area is the demand for new workers growing faster.[24] To meet this demand, an additional 1.3 million in-home providers must be added to the existing workforce of nearly two million providers.[25]

2. In the face of this growing need, the traditional labor pool for these jobs is stagnant. States have historically drawn in-home workers from a labor pool of women aged 25-54.[26] In fact, women make up nearly 90% of direct care workers.[27] Yet nationally this labor pool is projected to increase by just 1% over the next decade.[28] Thus, the expected

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[24] *Fastest Growing Occupations*, Bureau of Labor Statistics, U.S. Dep't of Labor (Feb. 1, 2012) [hereinafter Bureau of Labor Statistics], http://www.bls.gov/emp/ep_table_103.htm.

[25] *Id.* Many are also calling for personal care aides, specifically, to play a greater role in coordinating with medical professionals who care for beneficiaries. *See, e.g.*, Janet M. Coffman & Susan A. Chapman, *Envisioning Enhanced Roles for In-Home Supportive Service Workers in Care Coordination for Consumers with Chronic Conditions: A Concept Paper* 4 (2012), *available at* http://tinyurl.com/PHI-Coffman; Susan C. Reinhard, *A Case for Nurse Delegation Explores a New Frontier in Consumer-Directed Patient Care*, Generations, Winter 2010-11, at 75. The result is that states will not only need a far larger pool of homecare workers to fulfill these new roles, but also a workforce with the capacity and stability for related skills training.

[26] *See* PHI, *Facts 1: Occupational Projections for Direct-Care Workers 2010-2020* 4 (Feb. 2013), *available at* http://tinyurl.com/PHI-Facts1.

[27] *See* PHI, *Facts 3: America's Direct-Care Workforce* 7 (Nov. 2013), *available at* http://tinyurl.com/PHI-Facts3.

[28] PHI, *Facts 1*, *supra*, at 4.

demand for new homecare workers (1.3 million)[29] vastly exceeds the number of women in this age group projected to enter the labor force (612,350).[30]

State level data confirm these problems. In 2007, PHI conducted a survey of state Medicaid agencies and aging agencies: 97% of states reported "serious" or "very serious" shortages in their direct-care workforce.[31] Similarly, in 2012 the National Association of States United for Aging and Disabilities found that 84% of states reported serious concern about the lack of sufficient direct-care workers to meet beneficiaries' demand—nearly double the concern expressed in prior years.[32] Furthermore, individual states consistently report shortages within their homecare workforce.[33]

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[29] Bureau of Labor Statistics, *supra*.

[30] PHI, *Facts 1*, *supra*, at 4.

[31] PHI & Direct Care Workers Ass'n of N.C., *The 2007 National Survey of State Initiatives on the Direct-Care Workforce: Key Findings* 2 (2009), *available at* http://tinyurl.com/PHI-2007Survey.

[32] Nat'l Ass'n of States United for Aging and Disabilities, *2012 State of Aging and Disabilities Survey* 12 (2012), *available at* http://tinyurl.com/PHI-NASUAD.

[33] *See, e.g.*, Julie Robison et al., Univ. of Conn. Health Ctr., *Connecticut Long-Term Care Needs Assessment: Executive Summary* 15 (2010), *available at* http://tinyurl.com/PHI-Conn; Iowa Dep't of Pub. Health, *The Future of Iowa's Health and Long-Term Care Workforce* 11-12 (2007), *available at* http://tinyurl.com/PHI-Iowa; Gail MacInnes & Dorie Seavey, PHI, *Home Care at a Crossroads: Minnesota's Impending Long-Term Care Gap* 9 (2012), *available at* http://tinyurl.com/PHI-MacInnes.

B. Persistent Turnover Imposes Considerable Costs On States And Program Beneficiaries.

Turnover problems plague the homecare workforce, inhibiting the states' ability to secure a sufficient reserve of workers to serve all beneficiaries. Numerous studies confirm that turnover for personal care aides ranges "from 44 to 65 percent per year"[34]; put in slightly different terms, half of all providers leave their jobs each year. Left unremedied, such high rates of provider turnover result in significant costs for both the state providing care and the individuals receiving it.

Turnover is a "critical cost driver for the long-term care industry."[35] Existing empirical literature finds that turnover of *each individual worker*

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[34] Application of the Fair Labor Standards Act to Domestic Service, 78 Fed. Reg. 60,543 (Oct. 1, 2013) (to be codified at 29 C.F.R. pt. 552) (citing Dorie Seavey & Abby Marquand, PHI, *Caring in America: A Comprehensive Analysis of the Nation's Fastest Growing Jobs: Home Health and Personal Care Aides* 70 (2011)); *see also, e.g.*, Amy Hewitt & Sheryl Larson, *The Direct Support Workforce in Community Supports to Individuals with Developmental Disabilities: Issues, Implications, and Promising Practices*, 13 Mental Retardation & Developmental Disabilities Res. Revs. 178, 180 (2007) (reporting 52% turnover for persons caring for those with intellectual and developmental disabilities); Lisa Morris, *Quits and Job Changes Among Home Care Workers in Maine: The Role of Wages, Hours, and Benefits*, 49 Gerontologist 635, 644 (2009) (reporting 46% turnover of agency-employed home care workers in Maine).

[35] Dorie Seavey, *The Cost of Frontline Turnover in Long-Term Care* 4 (2004), *available at* http://tinyurl.com/PHI-Seavey2.

increases the direct cost of providing services by $2500.[36] Thus, the costs from turnover results in "an implicit tax on the reimbursement rates paid to publicly-financed providers—a hidden tax which ultimately is paid by tax payers for high industry turnover costs."[37]

When providers leave their jobs, beneficiaries "experience an interruption of services and the burden of getting used to and training [a] new employee."[38] And beneficiaries "may have to accept a period of potential low quality or unsatisfactory care while the new employee gains experience."[39] Many will be forced to forgo care altogether. In Arizona, for example, beneficiaries experienced "grave consequences" from service gaps "such as complete immobility, hunger, thirst, muscle aches, and other physical and mental distresses." *Ball v. Rodgers*, 492 F.3d 1094, 1101 (9th Cir. 2007) (internal quotation marks omitted). Ultimately, these gaps can force beneficiaries to visit an emergency room or seek other stopgap care, with states bearing the costs.

C. Working Conditions Are A Major Driver Of The Labor Problems States Face.

States confront a labor market that is poorly structured to provide a stable cadre of personal

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[36] *Id.* at 11.

[37] *Id.* at 20.

[38] Lori Simon-Rusinowitz et al., *Expanding the Consumer-Directed Workforce by Attracting and Retaining Unaffiliated Workers*, 11 Care Mgmt. Js. 74, 75 (2010).

[39] *Id.*

assistants available to meet the states' programmatic needs. The recruitment and retention difficulties arise largely from the "relatively low status, poor pay, and difficult working conditions" of these workers.[40]

1. Low pay and limited benefits frustrate recruitment and drive turnover. Studies consistently cite this factor when discussing the "deficit of direct-care workers."[41] In 2012, the national median hourly wage for personal care aides was $9.57.[42] In two-thirds of states, fulltime providers at the average hourly wage earn below 200% of the federal poverty level for individuals in one person households.[43] Those with children or other dependents are likely to be near the poverty level. Furthermore, approximately one third of aides lack health insurance, with uninsurance rates outside of agencies running as high as 45%.[44] It is therefore no surprise that over half of homecare aides and personal

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[40] A.E. Benjamin et al., *Retention of Paid Related Caregivers: Who Stays and Who Leaves Home Care Careers?*, 48 Gerontologist 104, 105 (2008).

[41] Inst. of Med., *supra*, at 200.

[42] *Economic News Release*, Bureau of Labor Statistics, U.S. Dep't of Labor (Mar. 29, 2013), http://www.bls.gov/news.release/ocwage.t01.htm (see entry for "Personal Care Aides").

[43] *See* PHI, *State Chart Book on Wages for Personal Care Aides, 2002-2012* 6 (Dec. 2013), *available at* http://tinyurl.com/PHI-ChartBook (listing each state's mean wage as compared to the federal poverty level).

[44] PHI, Facts 4: Health Care Coverage for Direct-Care Workers (March 2011), *available at* http://tinyurl.com/PHI-Facts4.

assistants live in households that receive some form of government assistance, such as cash welfare, medical assistance, or food stamps.[45]

2. The problems that cause recruitment and retention difficulties go far beyond poor compensation.

First, the work is often only part time. In 2011, 59% of aides reported working part time for at least some of the year.[46] PHI recently found that 40% of aides who worked part time reported that they would prefer more hours, but were unable to find additional work.[47] For many personal assistants, any guarantee of "stable hours last only until their current client dies or is hospitalized."[48] Workers have a limited ability to locate beneficiaries in need of additional support. In many states, decentralized, consumer-directed arrangements lack organized mechanisms for matching consumers in need with available workers.[49]

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[45] *See* Dorie Seavey & Abby Marquand, PHI, *Caring in America: A Comprehensive Analysis of the Nation's Fastest Growing Jobs: Home Health and Personal Care Aides* 67 (2011) [hereinafter PHI, *Caring in America*], *available at* http://tinyurl.com/PHI-Caring.

[46] *See* PHI, *Facts 3*, *supra*, at 4.

[47] PHI, *Caring in America*, *supra*, at 62.

[48] *Id.* at 60.

[49] *Id.* at 28; *see also* Dorie Seavey & Abby Marquand, *Building Infrastructure to Support CLASS: The Potential of Matching Service Registries* 3 (The SCAN Found., CLASS Technical Assistance Brief Series No. 16, 2011), *available at* http://tinyurl.com/PHI-SCAN.

Second, shifts themselves may often be short, unpredictable, and not worth the cost to the worker. A provider may work only a few hours per day or be required to work a split shift based on the beneficiary's needs.[50] Providers are seldom compensated for travel to and from beneficiaries' homes.[51] And beneficiaries' needs may be unpredictable,[52] limiting providers' abilities to plan their lives or the time they can commit to additional clients (if they can find them).

Third, workers face a significant risk of workplace injury. Patients' homes are "rarely designed as safe workplaces."[53] But personal assistants must often perform a series of demanding physical tasks, and they "often lack appropriate assistive devices for lifting, carrying, and supporting clients."[54] Working at dispersed worksites, homecare aides may fail to receive training to deal with the

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[50] Decl. of Frances Smith at ¶¶ 9, 11, *Oster v. Lightbourne*, No. 09-cv-04668-CW (N.D. Cal. Dec. 1, 2011), ECF No. 400; Corrected Decl. of Kerry Bargsten at ¶ 10, *Oster v. Lightbourne*, No. 09-cv-04668-CW (N.D. Cal. Dec. 5, 2011), ECF No. 421-1 [hereinafter Bargsten Decl.].

[51] PHI, *Caring in America*, *supra*, at 60.

[52] Bargsten Decl., *supra*, at ¶¶ 7-8.

[53] PHI, *Caring in America*, *supra*, at 48.

[54] *Id.*

unique needs of individual beneficiaries.[55] As a result, injuries occur often.[56]

For a variety of reasons, ranging from the lack of workers' compensation or other income support to a sense of responsibility for clients who will otherwise be left unattended, homecare workers often find themselves trying to work while injured. "Unaddressed injuries on the part of aides can worsen through continued overexertion and physical and emotional stress, ultimately worsening the

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[55] *Id.* at 49; *see also* Abby Marquand, PHI, *Personal Care Aide Training Requirements: Summary of State Findings* 4-5 (2013), *available at* http://tinyurl.com/PHI-Marquand.

[56] The structure of a decentralized workforce may actually mask the extent workplace injuries. Homecare worker injury rates "may be severely underestimated, largely because independent providers are generally ignored by current surveillance mechanisms." Inst. of Med., *supra*, at 212. The well-documented nursing home direct care staff injury rate is instructive. Nursing aides, orderlies, and attendants have "one of the highest rates of workplace injury among all occupations," and in 2006 the incidence of non-fatal occupational injury for these workers was "four times the average rate among all occupations," even higher than the rate for truck drivers and construction workers. *Id.* Reflecting the demanding nature of homecare work, personal assistants experience the *highest* rate of depression lasting two weeks or longer among *all* U.S. workers. PHI, *Caring in America*, *supra*, at 45. Whatever the injury rate, the data suggest that injury severity is likely higher with respect to homecare workers than with respect to nursing home and hospital workers. When it comes to reported injuries, homecare workers miss more than double the number of days missed by their institutional counterparts, "suggesting that injuries among home-based workers may be more severe and disabling." *Id.* at 48.

quality of care delivered to clients."[57] Without adequate support, injured workers will leave the homecare field either because they can no longer perform the job or because they decide that a job that impairs their own health is not worth having.

Fourth, worker backup arrangements are more difficult in consumer-directed programs,[58] so workers face difficulties taking time off for illnesses, dependent care, or special events. While an individual in a conventional workplace may find a substitute among coworkers, for homecare workers missing work may mean leaving a beneficiary bedridden or unfed.

Fifth, late payments are a chronic problem.[59] Workers do not interact on a daily basis with the state that pays for their employment. It may

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[57] *Id.* at 45.

[58] *See* Dorie Seavey & Vera Salter, *Bridging the Gaps: State and Local Strategies for Ensuring Back-up Personal Care Services* (Oct. 2006), *available at* http://tinyurl.com/PHI-Bridging.

[59] *See, e.g.*, Press Release, Am. Fed'n of State, Cnty. & Mun. Emps., Home Care Workers Protests Late Pay (Feb. 1, 2005), *available at* http://tinyurl.com/PHI-AFSCME (reporting that in Iowa late payments were "routinely" a problem "for workers all across the state"); Eric Boehm, *Payroll Problems for Home-Care Workers Cost Taxpayers Millions*, Pocono Record (Nov. 16, 2013), http://tinyurl.com/PHI-Boehm (late-payment problems resulted in thousands not being paid for months, expensive disruptions in service, a need for system upgrades, and customers seeking more expensive care, costing taxpayers approximately $7 million).

therefore be difficult for them to resolve these disputes and seek full payment.

Finally, the absence of a clear path to more advanced positions means that workers are more likely to view their job as a temporary post rather than as part of a career.[60]

These problems will be especially pressing to the main demographic group from which homecare workers are drawn: low-income women.[61] These women often have families. "[F]emale direct-care workers are more likely to be single mothers than are female workers in general."[62] Moreover, "of those who are single parents, 35 percent to 40 percent are below the poverty line."[63]

It is important to understand that unless the state can solve these problems, workers will defect to other jobs that, even if they provide the same hourly wage, are less likely to suffer from these additional disadvantages. A worker at a fast-food restaurant may have predictable shifts and coworkers with whom she can switch shifts if she needs to. A worker at a conventional worksite can more easily contact a human resources department to resolve pay issues. And a worker in a low paying retail job may have

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[60] *See, e.g.*, Benjamin et al., *supra*, at 106; Ruth Matthias et al., Cal. Emp't Dev. Dep't, *Caregiving Training Initiative: Final Process and Outcome Evaluation Report* 101 (2003), *available at* http://tinyurl.com/PHI-Matthias.

[61] *See* PHI, *Facts 3*, *supra*, at 7.

[62] Inst. of Med., *supra*, at 204.

[63] *Id.*

opportunities to advance to a supervisory position. Thus, it is not surprising that at the recruitment stage, potential providers are led to consider "a number of immediate, less stressful job alternatives, such as those offered by the food and hospitality industries."[64] And at the retention stage, current workers are "[i]nevitably" tempted "to move out of home-based caregiving jobs to improve their basic economic security."[65]

D. The Consumer-Directed Homecare Model Introduces Labor Market Problems That Are Beyond The Power Of Individual Beneficiaries To Fix.

Consumer-directed models can increase the stability of individual beneficiary-provider relationships, when a good provider can be found. But they do little on their own to keep workers in the field writ large. Without the state playing an active workforce building role, the state cannot rely on individual beneficiaries' choices to produce a cohort of experienced providers available to serve additional clients eligible for state services.

Neither individual low-income Medicaid beneficiaries nor individual low-income homecare providers have the expertise, the resources, or the incentives to address imperfections in the labor market. Individual beneficiaries may use consumer-directed models as a way of compensating family

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[64] *Id.* at 209.

[65] Morris, *supra*, at 648.

members who provide them with care. That is what happened in petitioners' case. But those beneficiaries are unlikely to care whether petitioners will go on to provide care to other Medicaid participants as well.

By contrast, the state *does* have a strong interest in encouraging experienced homecare providers to remain in the workforce. Large numbers of beneficiaries must look outside their immediate circle for homecare providers, and the state is responsible for providing those workers. Indeed, many beneficiaries desire or need to "turn to unaffiliated directly hired workers,"[66] either because they prefer an arms-length relationship offering greater autonomy or because they have needs that cannot be met by family members.

State experiments with "Cash and Counseling" programs illustrate the problems when consumer direction is not coupled with active state development of an adequate workforce. In those programs, states set few employment standards, instead simply providing consumers with an allowance to pay wages to a private provider, permitting moneys not spent on wages to be used for other approved purposes such as assistive technology.[67] Yet one five-year study found that "[s]ubstantial portions" of potential beneficiaries could not actually participate in the program "often because they could not find anyone to hire."[68] States

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[66] Simon-Rusinowitz et al., *supra*, at 74.

[67] For a discussion of "Cash and Counseling" programs, see generally Robert Wood Johnson Found., *supra*.

[68] Randall Brown et al., Mathematica Policy Research, Inc., *Cash and Counseling: Improving the Lives of Medicaid*

simply cannot ignore labor shortages in the hope that the market will respond adequately.

III. States Deserve Latitude To Address Homecare Labor Market Issues By Offering Collective Bargaining To Their Homecare Workforce.

States must affirmatively build the workforce they need. They could choose to act unilaterally, but many states have concluded that the wiser course of action is more collaborative. Given states' long experience with managing a variety of workforces, many of them have concluded that they are more likely to adopt changes that produce a skilled, stable workforce when they turn to tried-and-true labor relations institutions. So it is no surprise that several states have offered an opportunity for collective bargaining to the homecare workers whose salaries they pay, regardless of where those workers perform those jobs.

A. States Have Good Reason To Believe That Offering Collective Bargaining To Workers Can Improve The Effectiveness of Their Homecare Programs.

Without fixing the problems that plague the current labor market, states cannot successfully operate the consumer-directed, home-based programs they have justifiably chosen. There are a variety of paths that states might pursue to improve working

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Beneficiaries Who Need Personal Care or Home- and Community-Based Services: Final Report 95 (2007), *available at* http://tinyurl.com/PHI-Brown.

conditions and thereby attract and retain workers. Collective bargaining is one path that enjoys wide empirical and theoretical support. If anything, the state has distinctive justifications for offering it here.

1. Unionization allows states to capture the benefits of a consumer-directed model while creating an efficient infrastructure.

The benefits of offering a consumer-directed model are straightforward: program beneficiaries exercise substantial control in deciding who provides their care and how it is provided. But as already explained, states must necessarily continue to exert significant control over job duties, wage and benefits packages, and worker qualifications—both in order to ensure that their programs provide high quality care and to keep costs in line.

At the same time, home-based, consumer-directed homecare produces a state-financed workforce that is scattered across literally thousands of workplaces. States obviously need some tool for determining what combination of employment terms will best achieve the states' constellation of goals, and for responding to problems that inevitably arise from carrying out a complex government program.

Many states have long allowed collective bargaining to serve these needs. Collective bargaining creates an infrastructure through which the state can efficiently negotiate the terms of workers' employment, determine what mix of benefits will best attract and retain them, and resolve disputes quickly and equitably.

2. Collective bargaining enables states to manage their workforce and resources more effectively.

Contrary to petitioners' suggestion, Petr. Br. 42-43, collective bargaining differs materially from other methods for soliciting information. Unlike polls, questionnaires, or casual conversations around a non-existent water cooler, collective bargaining does not rely on individual, dispersed, poorly resourced workers.[69] Rather, as states have experienced for years with other portions of their workforce, collective bargaining channels, concentrates, and communicates worker preferences and priorities so that states can manage their workforce in a way that leads to more creative and effective solutions to complicated questions of workforce administration.

a. Unions can assist in creating open and effective lines of communication between dispersed workers and management, both in the contract negotiation process and in day-to-day operations.[70] Regular, effective dialogue between the state and its workforce's selected representative is essential to designing benefit programs and dispute resolution

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[69] Each of these workers of course retains his right to petition the government. Nothing in collective bargaining would, for example, stop a home care aide from contacting his state legislator with his concerns about the way the state is running its program.

[70] *See, e.g.*, Richard B. Freeman & James L. Medoff, What Do Unions Do? 94-110 (1984) (arguing that one of the primary benefits of unions is the "'exit-voice' tradeoff," which provides "discontented workers with a voice alternative to quitting" and permits workers to communicate their preferences at a low cost in a way that increases management's legitimacy).

systems, determining workers' collective preferences, and reinforcing the legitimacy of state decisions.[71]

In the negotiation process, states need to understand, given their limited resources, which package of benefits will be most attractive to current and potential workers and how to design benefits packages most effectively. Unions are well situated and incentivized to provide the necessary information.

Surveys or focus groups are a poor substitute for unions because they do not permit workers to discuss each other's concerns, learn from each other's experiences, or access relevant expertise. A union, however, can engage its members to determine priorities within a shared agenda and draw on otherwise unavailable expertise. For example, would workers prefer training programs or transportation subsidies? How important are flexible hours relative to predictable schedules? Union services are especially valuable where the workforce is widely dispersed, does not interact with the employer regularly, and has no history of enjoying benefits from which the state can intuit preferences.

In Illinois, collective bargaining led to state-funded health benefits through a union administered, state-audited program, jointly administered training and orientation programs, development of a registry to assist beneficiaries locate bargaining unit

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[71] *See, e.g.*, Stephen F. Befort, *A New Voice for the Workplace: A Proposal for an American Works Council Act*, 69 Mo. L. Rev. 607, 609-16 (2004).

members for work opportunities, and a grievance procedure.[72] Collective bargaining in other states has developed similar benefits, as well as others. For example, union contracts in some California counties provide for a "Job Development Fund that reimburses homecare workers for continuing education."[73] In short, unions can substantially help states better navigate the tradeoffs they face in determining which benefits to offer or policies to enact.

b. At the same time, unions are also well positioned, because of frequent input from their members, to help states in developing care standards. For instance, in Washington State, the union collaborated with the state to create and sponsor a nonprofit school that delivers training to more than 40,000 homecare aides across more than 100 sites annually in thirteen languages.[74] This training partnership not only builds a career pathway for homecare aides, but provides training in the areas that providers have identified as being the most

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[72] See Agreement between the State of Illinois and the Service Employees International Union, *available at* http://tinyurl.com/PHI-Agree.

[73] Nari Rhee & Carol Zabin, *The Social Benefits of Unionization in the Long-Term Care Sector*, *in Academics on Employee Free Choice* 83, 89 (John Logan ed. 2009).

[74] *Addressing LTSS Service Delivery and Workforce Issues: Hearing Before the Comm'n on Long-Term Care*, U.S. Senate 108-10 (Aug. 20, 2013) (testimony of Charissa Raynor, Exec. Dir., SEIU Healthcare Nw. Training P'ship & Health Benefits Trust), *available at* http://tinyurl.com/PHI-Hearing.

crucial given their work experience.[75] And unions, because they communicate regularly with their members, can provide their members with information and assistance about state standards and how to comply with them. States benefit from the increased compliance.[76]

c. Virtually every collective bargaining agreement includes a dispute resolution process because such processes are more cost-effective than litigation.[77] Given that state-run homecare programs rely on a widely dispersed, low-income population working in isolated settings, the existence of a low-cost means of enforcing rights is critical. Once a contract has been signed, unions are indispensable participants in that process.

Such processes are particularly important in resolving homecare payment disputes. Providers work inconsistent hours and often serve multiple beneficiaries to cobble together a full-time schedule. These factors can lead to delayed payment, a

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[75] *Id.* at 110.

[76] *See, e.g.*, Cynthia Estlund, Regoverning the Workplace: From Self-Regulation to Co-Regulation 241-43 (2010); David Weil, The Fissured Workplace: Why Work Became So Bad for So Many and What Can Be Done to Improve It (forthcoming 2014) (finding the presence of a union results in more effective enforcement practices).

[77] *See* Harry T. Edwards, *Advantages of Arbitration Over Litigation: Reflections of a Judge*, *in Arbitration 1982: Conduct of the Hearing, Proceedings of the 35th Annual Meeting of the NAA* 16 (James L. Stern & Barbara D. Dennis eds., 1983) (discussing an ABA report regarding the advantages of labor arbitration processes).

particularly pressing problem for workers living paycheck to paycheck. These workers may lack the sophistication either to understand their legal rights or to vindicate those rights on their own. But having an experienced, well-resourced union representative can assist them in obtaining the wages they have earned and can increase the dispute resolution process's credibility. Moreover, the union is far more likely than isolated, individual workers to identify systemic problems and to negotiate effective solutions.[78]

3. Unions also provide a variety of services to their members that increase workforce retention.[79]

a. Unions foster opportunities for training and skill development.[80] For example, union mentorship programs can be especially important in settings where workers are dispersed. The building trades have long illustrated this point,[81] and unions

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[78] *Cf.* Douglas L. Leslie, *Labor Bargaining Units*, 70 Va. L. Rev. 353, 354-60 (1984) (noting that unions are more likely to negotiate "collective goods").

[79] *See* Richard B. Freeman, *The Effect of Unionism on Worker Attachment to Firms*, 1 J. Lab. Res. 29, 30 (1980).

[80] *See, e.g.*, Paul Osterman & Beth Shulman, Good Jobs America: Making Work Better For Everyone 90, 105-115 (2011) (finding that unions can provide opportunities for workers to upgrade their occupational skills and abilities and can help construct career pathways that enable workers to advance in the field).

[81] Thomas Kochan et al., *Who Can Fix the "Middle-Skills" Gap?*, Harv. Bus. Rev., Dec. 2012, at 83, 85-86.

representing homecare workers have developed similar programs.[82]

b. Unions can also contribute to a productive work environment by increasing worker morale.[83] By giving workers a feeling of control over their work lives, collective bargaining lends credibility to state decisions, and makes workers more likely to view the homecare provider field as supporting a career rather than just a job.[84]

A study on the impact of cooperative union-management relations involving an analogous workforce at Kaiser Permanente supports this intuition. That study found that higher levels of engagement and effectiveness between management and unionized workers were associated with lower workplace injuries, higher rates of hospital quality, lower absenteeism, and higher patient satisfaction.[85]

c. A collaborative relationship between the union and state can also produce more creative solutions to

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[82] *See, e.g.*, Rhee & Zabin, *supra*, at 88 (noting a Washington State mentorship program).

[83] *See* Freeman & Medoff, *supra*, at 162-80 (1984) (finding that most quantitative studies of productivity conclude that unionized establishments are more productive than otherwise comparable nonunion establishments).

[84] *Cf.* Dale Belman, *Unions, The Quality of Labor Relations, and Firm Performance*, *in* Unions and Economic Competitiveness 41, 71 (Lawrence Mishel & Paula B. Voos eds., 1992).

[85] *See generally* Thomas A. Kochan et al., Healing Together: The Labor-Management Partnership at Kaiser Permanente (2009).

homecare problems. For example, a California homecare union partnered with a network of federally qualified health centers in a program where providers became part of the beneficiary's medical team to better coordinate treatment, identify gaps in care, and follow physician diagnoses.[86] Over two-thirds of patients receiving care from providers enrolled in the pilot "reported an improvement in their health-related quality of life."[87]

d. Finally, unions can help in the matching process that undergirds consumer-directed care. Local unions often work with the state to create and operate referral and registry systems.[88] Without such systems, unsophisticated consumers may be unable to find providers who have the right skills and availability. Union-assisted referral and registry systems can assist workers in finding initial positions, relief and respite for vacations or illness, and successor employment.

4. To be sure, collective bargaining is often associated with increased compensation for unionized workers. For instance, a study based on nationwide survey data of low-income workers concluded that "unionization raised workers' wages by just over 16

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[86] St. John's Well Child & Family Ctr, *The Power of Partnership: Annual Report 2012* 12 (2012), *available at* http://tinyurl.com/PHI-StJohns.

[87] St. John's Well Child & Family Ctr., *Development Newsletter* (Feb. 2013), *available at* http://tinyurl.com/PHI-StJohns2.

[88] Seavey & Marquand, *Building Infrastructure*, *supra*, at 2.

percent—about $1.75 per hour—compared to those of non-union workers" and that union workers "were 25 percentage points more likely to have employer-provided health insurance."[89] But because "ensuring good quality care hinges on the ability of policymakers to address the adequacy of the wages and benefits typically paid to direct-care workers,"[90] the available evidence strongly suggests that the increased compensation achieved through collective bargaining serves the interests of states and program beneficiaries as well as providers.

In California, for example, "unions and home care consumers who recognized their mutual interest in a well-paid, stable workforce" have transformed home healthcare.[91] Once workers in San Francisco achieved significant wage increases through collective bargaining, annual retention of new workers increased from 39% to 74%.[92]

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[89] John Schmitt et al., Ctr. For Econ. & Policy Research, *Unions and Upward Mobility for Low-Wage Workers* 2 (2007).

[90] Dorie Seavey & Vera Salter, AARP Pub. Policy Inst., *Paying for Quality Care: State and Local Strategies for Improving Wages and Benefits for Personal Care Assistants* vi (2008).

[91] Candace Howes, *Upgrading California's Home Care Workforce: The Impact of Political Action and Unionization*, *in The State of California Labor* 71, 72 (Univ. of Cal. Inst. for Labor & Emp't, 2004).

[92] Candace Howes, *Living Wages and Retention of Homecare Workers in San Francisco*, 44 Indus. Rel. 139, 139 (2005).

Giving health insurance to providers in California also increased the probability that a worker remained in his job for at least one year by 21%.[93] In fact, the study concluded that one of the most important factors in attracting and retaining workers in California was providing health insurance.[94] Prior to unionization, no counties in California offered health insurance to in-home providers through their job. But as of 2008, 45 of 58 counties offered health insurance, 31 offered dental coverage, and 20 offered vision coverage.[95] Other California counties now provide transportation subsidies and sick and vacation leave.[96]

The experience in Washington State is similar. Unionized providers in Washington negotiated contracts that not only increased wages, but also created "a wage scale based on cumulative career experience."[97] These contracts also added health benefits (ultimately including vision and dental insurance) as well as workers' compensation insurance.[98] Such contracts are bound to increase retention rates: prior to their adoption, roughly one-third of Washington State providers responded that

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[93] *Id.* at 141.

[94] Candace Howes, *Love, Money, or Flexibility: What Motivates People to Work in Consumer-Directed Home Care?*, 48 Gerontologist 46, 58 (2008).

[95] Rhee & Zabin, *supra*, at 88.

[96] Seavey & Salter, *supra*, at 18.

[97] *Id.* at 19.

[98] *Id.*

they were more likely to stay in the in-home health care field if they received health insurance.[99]

5. While it may seem counterintuitive at first, raising homecare workers' compensation as part of a package of changes to working conditions may actually reduce a state's overall costs. Underpaying homecare workers is false economy. On the one hand, underpaying workers may ultimately increase costs through unnecessary hospitalization, institutionalization, and replacement costs for beneficiaries who lose their provider. On the other hand, creating packages that improve compensation and other working conditions may generate greater program efficiencies, by leading workers to stay in the job over a career.

Poor pay and benefits may especially force states to incur additional costs when they deal with a workforce composed disproportionately of women with children. Such conditions may force workers to seek such government assistance as food stamps, Medicaid, housing vouchers, or free school lunches. Indeed, in Wisconsin, the fiscal cost of providing such benefits to homecare providers alone is "tantamount to a public subsidy of $1 to $2 for every hour worked by a Wisconsin direct-care worker."[100] Thus, poor conditions simply divert government spending from

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[99] Dave Pavelchek & Candiya Mann, Wash. State Univ., *Evaluation of Interventions to Improve Recruitment and Retention: Summary of Results for the Washington State Home Care Quality Authority* 9-10 (2007).

[100] PHI, *State Facts: Wisconsin's Direct-Care Workforce* 5 (2011), *available at* http://tinyurl.com/PHI-WI.

one line item to another. Unlike private employers, then, states cannot externalize these costs. Rather, states eventually internalize all the negative consequences of labor instability among homecare workers.

States thus have good reason to conclude that offering collective bargaining is a cost-effective mechanism to create a skilled and stable workforce that will more effectively implement state programs caring for their most vulnerable citizens.

B. This Court Has Recognized That States Must Have Latitude To Determine How Best To Manage The Workforces That Carry Out State Functions.

The Illinois Medicaid programs at issue in this case are undoubtedly state operations. This Court has "long held the view that there is a crucial difference, with respect to constitutional analysis," between the government acting as a regulator of private activity "and the government acting 'as proprietor, to manage [its] internal operation.'" *Engquist v. Or. Dep't of Agric.*, 553 U.S. 591, 598 (2008) (alteration in original) (citation omitted). It is "well-established" that the Government is "granted the widest latitude in the 'dispatch of its own internal affairs.'" *Sampson v. Murray*, 415 U.S. 61, 83 (1974) (citation omitted). Thus, in striking the balance between an individual's First Amendment claims and the government's interests, the Court has "'consistently given greater deference'" to the government in this context. *Bd. of Cnty. Comm'rs v. Umbehr*, 518 U.S. 668, 676 (1996) (citation omitted);

see also Pickering v. Bd. of Educ., 391 U.S. 563, 568 (1968).

The government, like private employers, needs the ability to manage its relationship to the individuals who carry out its business since, "without it, there would be little chance for the efficient provision of public services." *Garcetti v. Ceballos*, 547 U.S. 410, 418 (2006). Achieving efficiency "'is elevated from a relatively subordinate interest" when the government regulates the public "to a significant one when it acts as employer.'" *Engquist*, 553 U.S. at 598 (citation omitted). Moreover, this Court has emphasized that the greater latitude states enjoy in supervising state programs depends on the "nature" of the work being performed and not on the "formal status" of the individuals performing it. *NASA v. Nelson*, 131 S. Ct. 746, 759 (2011). Thus, this Court held, in the context of background checks for government contractors, that even if questions asked of a government contractor's employees "implicate[d] a privacy interest of constitutional significance," the questions were "reasonable" in light of government interests "in managing its internal operations." *Id.* at 751, 756.

This Court has therefore accorded states deference when they decide that offering collective bargaining to a state workforce contributes to the efficient provision of government services. This Court has consistently rejected First Amendment challenges either to states' decisions to offer collective bargaining or to requirements—like the one at issue here—that public sector employees "who do not wish to join a union" pay it "a service fee as a condition of their continued employment." *Locke v. Karass*, 555

U.S. 207, 213 (2009). Nothing in this Court's decisions suggests that states must sacrifice that prerogative when they deploy their workforce in the way best calculated to achieve the states' programmatic goals.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be affirmed.

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