

**NATIONAL FEDERATION OF INDEPENDENT BUSINESS'S IMPACT ON
STATE MEDICAID PROGRAMS & THE RISE OF FEDERALISM BY
WAIVER**

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INTRODUCTION

On March 23, 2010 President Barack Obama signed the Patient Protection and Affordable Care Act (hereinafter “ACA”) into law.¹

The enactment of the ACA was an enormous step in the history of the United States, as “no prior administration had successfully pushed national health reform through Congress, despite several attempts.”² The Act was created with the primary goal of providing all American citizens with quality, affordable healthcare while also establishing mechanisms to curb the unsustainable growth of healthcare costs in the United States.³

In order to achieve one of its main objectives—the expansion of healthcare coverage to currently uninsured citizens—the ACA contains provisions that extend Medicaid to all individuals earning less than 133% of the federal poverty level (FPL).⁴ The act also provides subsidies, through healthcare exchanges, to Americans earning between 133% and 400% of the FPL, without access to affordable employer-sponsored health insurance.⁵ The Congressional Budget Office estimates that these provisions, along with others such as the “minimal essential coverage provision” or “individual mandate,” will increase the number of individuals with coverage by thirty-two million

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1 Scott E. Harrington, *U.S. Healthcare Reform: The Patient Protection and Affordable Care Act*, 77 J. RISK & INS. 703, 703 (2010).

2 Bradley W. Joondeph, *Federalism and Healthcare Reform: Understanding the States' Challenges to the Patient Protection and Affordable Care Act*, 41 J. FEDERALISM 447, 447 (2011).

3 James F. Freeley III, *National Federation of Independent Business v. Sebelius: The Constitutionality of Healthcare Reform and the Spending Clause*, 45 CONN. L. REV. 19, 21–22 (2013).

4 H.R. Con. Res. 3590, § 2001(a)(1)(C)(VIII), 111th Cong. (2011) (enacted); *Federal Poverty Guidelines*, FAMILIES USA, <http://familiesusa.org/product/federal-poverty-guidelines> (last visited Mar. 23, 2014) (stating that, as of February of 2014, the FPL is set at \$11,670 for a single individual and \$23,850 for a family of four).

5 Adam N. Hofer et al., *Expansion of Coverage under the Patient Protection and Affordable Care Act and Primary Care Utilization*, 89 MILBANK Q. 69, 69 (2011).

before the year 2019,⁶ with approximately seventeen million individuals obtaining insurance through the Medicaid expansion.⁷

Predictably, not all Americans were enthusiastic about the passage of the Patient Protection and Affordable Care Act.⁸ Very soon after the ACA was signed into law, states began challenging the Act's constitutionality.⁹ Among these challenges, certain states contended that the ACA, which required states to expand Medicaid or lose all federal Medicaid funding, compelled them to implement a federal program in violation of both the Spending Clause and the Tenth Amendment.¹⁰ Even though the language of the ACA is nonobligatory,¹¹ the "importance of federal Medicaid funding in a typical state's budget means that states have little choice but to implement the [ACA's] changes to Medicaid."¹²

These constitutional challenges moved through the federal courts and were eventually resolved by the United States Supreme Court in *National Federation of Independent Business v. Sebelius*.¹³ In *Sebelius*, the Court upheld the ACA's "individual mandate"¹⁴ but ruled that the Medicaid expansion violated the Spending Clause of the Constitution since states really had no choice but to accept the expanded Medicaid funding.¹⁵ Thus, the Court ruled, new federal expansion funding could be withheld from the states that do not expand Medicaid, but Medicaid funding already being provided could not be taken away.¹⁶ The Court's decision in *Sebelius* effectively left the choice of whether to expand Medicaid entirely with the individual states.¹⁷ While the Court's decision in *Sebelius* may be viewed as a triumph of federalism, the decision has created potentially devastating problems for the ACA.

6 *Id.* at 70.

7 AM MED. ASS'N ADVOCACY RES. CTR., ISSUE BRIEF: MEDICAID EXPANSION (2013), <http://www.ama-assn.org/resources/doc/arc/medicaid-expansion-issue-brief.pdf>.

8 Joondeph, *supra* note 2, at 447.

9 *Id.*

10 *Id.* at 448.

11 H.R. Con. Res. 3590, 111th Cong. (2011) (enacted) (describing a state as an expansion state "if [the state] offers health benefits coverage statewide to parents and nonpregnant, childless adults whose income is at least 100% of the poverty line." Further, a state will not be considered an expansion state if the state only offers "health benefits coverage to parents or nonpregnant childless adults.").

12 Joondeph, *supra* note 2, at 448.

13 *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

14 *Id.* at 2600.

15 *Id.* at 2662-66.

16 *Id.*

17 *Id.*

As of February 18, 2015, twenty-two states had not yet decided whether they would expand Medicaid, with nineteen states leaning against expansion.¹⁸ The failure of these states to expand their Medicaid programs would leave approximately six million people, who were initially expected to gain coverage under the ACA, without any means of obtaining affordable healthcare.¹⁹ Thus, after *Sebelius*, securing affordable, quality coverage for all Americans will likely not be possible.

This Comment seeks to examine the alternative methods of a select group of states which have, or are considering, “opting-out” of the Medicaid expansion, plan to employ as a means of providing health coverage to their uninsured poor citizens. The Comment will begin, in Part I, with a brief discussion of the ACA’s Medicaid Expansion and the early state challenges to this provision’s constitutionality. Part II will contain a discussion of the Supreme Court’s resolution of these challenges in *National Federation of Independent Business v. Sebelius*. Parts III through V will then focus on the alternative programs proposed by Arkansas, Iowa, and Pennsylvania and whether these programs are an effective means of insuring low-income individuals. Further, the propriety and fairness of certain states’ decision not to participate in the ACA’s Medicaid expansion, while also declining to negotiate an alternate plan through a § 1115 waiver,²⁰ will be evaluated. The *Sebelius* decision’s overall impact on the success of the ACA will also be discussed. Finally, the Comment will conclude, in Part VI, with a discussion of “federalism by waiver” in the realm of cooperative federal and state programs in the aftermath of *Sebelius*.

I. THE MEDICAID EXPANSION & STATES’ CHALLENGES

Medicaid was created under Title XIX of the Social Security Act and became law in 1965 as a joint venture between the federal and

18 See *Where the States Stand on Medicaid Expansion: 28 States, D.C. Expanding Medicaid*, THE ADVISORY BD. CO. (Feb. 11, 2015 11:47 AM), <http://www.advisory.com/daily-briefing/resources/primers/medicaidmap>

19 See KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM: A GUIDE TO THE SUPREME COURT’S DECISION ON THE ACA’S MEDICAID EXPANSION 3 (Aug. 2012), available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8347.pdf>.

20 *Section 1115 Demonstrations*, MEDICAID.GOV, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html> (last visited Mar. 24, 2014) (explaining that § 1115 demonstration waivers “give the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs”).

state governments.²¹ Within a broad framework, established through the passage of federal statutes, regulations, and policies, “each State establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program.”²² Medicaid was specifically designed in this manner to give states extensive flexibility in administering their particular Medicaid programs, and, as a result, there exists a great deal of variation in eligibility requirements, even among states of similar size or geographic location.²³ Therefore, an individual who is eligible for Medicaid benefits in one state may not be eligible to receive those benefits in another state or may observe drastic differences in the “amount, duration, or scope of services provided.”²⁴

There are, however, federal guidelines that limit a state’s ability to deny Medicaid coverage to certain “categorically needy” groups of people or restrict the coverage of certain medical services.²⁵ In order for a state to receive federal Medicaid funding, which comprises over 20% of the average state’s total expenditures,²⁶ a state is required to provide coverage to such groups.²⁷ These groups with mandatory eligibility include pregnant women, children, adults with dependent children, people with disabilities, and seniors.²⁸

There are also “medically needy” groups of individuals to which states have the option of extending coverage and will receive federal

21 BARBARA S. KLEES, CHRISTIAN J. WOLFE & CATHERINE A. CURTIS, DEP’T OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., OFFICE OF THE ACTUARY, BRIEF SUMMARIES OF MEDICARE & MEDICAID: TITLE XVIII AND TITLE XIX OF THE SOCIAL SECURITY ACT AS OF NOVEMBER 1, 2009, at 18 (Nov. 1, 2009), *available at* <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/downloads/MedicareMedicaidSummaries2009.pdf>.

22 *Id.*

23 *Id.*

24 *Id.*

25 *Id.* at 18, 23 (explaining that limited income families with children under age six whose family income is at or below 133% of the FPL, pregnant women whose family income is below 133% of the FPL, infants born to Medicaid-eligible women for the first year of life with certain restrictions, Supplemental Security Income Recipients, recipients of adoption or foster care assistance under Title IV-E of the Social Security Act, special protected groups, all children under age 19 in families with incomes at or below the FPL, and certain Medicare beneficiaries are all categorically needy).

26 CTR. FOR CHILDREN AND FAMILIES & GEORGETOWN HEALTH POLICY INST., MEDICAID AND STATE BUDGETS: LOOKING AT THE FACTS 1-2 (Mar. 2011), *available at* <http://ccf.georgetown.edu/wp-content/uploads/2012/03/Medicaid%20and%20state%20budgets-2011.pdf>.

27 *See* KLEES, WOLFE & CURTIS, *supra* note 21, at 18–20.

28 *See* DEP’T OF HEALTH AND HUMAN SERVS., MEDICAID AT-A-GLANCE 2005: A MEDICAID INFORMATION SOURCE 1 (2005), *available at* <http://downloads.cms.gov/cmsgov/archived-downloads/MedicaidGenInfo/downloads/medicaidataglance2005.pdf>.

matching funds for doing so.²⁹ If, however, a state elects to extend coverage to the “medically needy,” there are federal requirements mandating that certain groups and certain services be included as part of such coverage.³⁰

Prior to the passage of the ACA, an individual would have to belong to one of the aforementioned “categorically needy” groups,³¹ or in certain states a “medically needy” group, and meet a state-established financial test³² to qualify for Medicaid. The income threshold for pregnant women and children was set by the federal government to be no less than 133% of the FPL.³³ For other individuals, however, that threshold can be, and in many states is, much lower. For seventeen states, the Medicaid eligibility level for parents with dependent children was set at or below 50% of the FPL, which is \$11,670 for a family of four.³⁴ In another seventeen states, the Medicaid eligibility level for parents with dependent children was still set below 100% of the FPL, or \$23,850 for a family of four.³⁵ In states with more restrictive Medicaid programs, as many as 55% of individuals living below 100% of the FPL are left without any form of health insurance.³⁶

As the ACA was written, almost every United States citizen under the age of sixty-five with an income below 133% of the FPL would qualify for Medicaid. Further, the Act provides “that the federal government will pay 100% of the costs of covering these newly eligible individuals through 2016.”³⁷ After that period expires, the federal government will gradually reduce its payment level to no lower than 90%.³⁸ Thus, the ACA anticipates very significant changes to the Medicaid programs of states with less generous Medicaid enrollment requirements.

The Medicaid expansion is a crucial element of the ACA, as one of the Act’s primary goals is to achieve near universal healthcare coverage in the United States. After the ACA’s implementation, roughly

29 See KLEES, WOLFE & CURTIS, *supra* note 21, at 20.

30 *Id.*

31 *Id.* at 18-20.

32 *Id.*

33 *Id.*

34 *Medicaid and CHIP Eligibility Table by State*, NAT’L CONFERENCE OF STATE LEGISLATURES, (2015) <http://www.ncsl.org/research/health/medicaid-eligibility-table-by-state-state-activist.aspx>

35 *Id.*

36 *Id.*

37 Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2601 (2012).

38 42 U.S.C. § 1396d(y)(1)(E) (2013).

thirty-two million people were expected to acquire affordable, quality health insurance.³⁹ While these individuals are expected to obtain healthcare through a variety of the ACA's provisions,⁴⁰ nearly seven-teen-million of the newly insured individuals were projected to gain coverage through the expansion of Medicaid.⁴¹ These provisions, which are largely just expansions and alterations of health insurance structures already in place in the United States, left policy makers very hopeful that universal healthcare coverage, thought to be crucial to the well-being of a citizenry in many nations, would finally be a reality in the United States.⁴² This optimism was, however, short-lived. On March 23, 2011, the day President Obama signed the ACA into law, Florida and twelve other states brought a lawsuit that challenged the constitutionality of the ACA's individual mandate and Medicaid expansion provisions.⁴³ Thirteen other states, several individuals, and the National Federation of Independent Business subsequently joined these Plaintiffs.⁴⁴

In *Florida ex. rel. Bondi v. United States Department of Health and Human Services*, plaintiffs challenged "the fundamental and 'mas-sive' changes in the nature and scope of the Medicaid program" as a violation of the Constitution's Spending Clause.⁴⁵ The plaintiffs argued that the expansion alters the Medicaid program to such an extent that states "cannot afford the newly-imposed costs and burdens" and that states will "have no choice but to remain in Medicaid as amended by the Act, which will eventually require them to 'run their budgets off a cliff.'"⁴⁶ The District Court for the Northern District of Florida, in ruling that the defendant was entitled to judgment as a matter of law on the Medicaid expansion issue, held that the costs and burdens imposed on states participating in the

39 Emily Whelan Parento & Lawrence O. Gostin, *Better Health, But Less Justice: Widening Health Disparities After National Federation of Independent Business v. Sebelius*, 27 NOTRE DAME J.L. ETHICS & PUB. POL'Y 481, 482 (2013).

40 For example, the elimination of insurer discrimination on the basis of pre-existing conditions and the creation of health insurance exchanges that pool risks. The exchanges will allow individuals earning between 134 and 400% of the FPL, and who are unable to obtain quality employment based healthcare coverage, to purchase insurance at a reasonable price. See FOCUS ON HEALTH REFORM, *supra* note 19, at 2–3.

41 *Id.* at 3.

42 See Parento & Gostin, *supra* note 39, at 482.

43 See Fla. ex rel. Bondi v. Dep't of Health & Human Servs., 780 F. Supp. 2d 1256, 1263 (N.D. Fla. 2011).

44 *Id.*

45 *Id.* at 1266.

46 *Id.*

program were not in excess of the powers granted to Congress under the Spending Clause on a “coercion” theory, given that participation in the Medicaid program was voluntary, that states had an option to “opt out,” and that Congress, when it enacted the Medicaid program, had expressly reserved right to alter or amend it.⁴⁷

The plaintiffs in *Bondi* then appealed the district court’s decision to the Eleventh Circuit Court of Appeals. In *Florida ex. rel. Attorney General v. United States Department of Health and Human Services*, the plaintiff states revived their argument that an additional restriction on Congress’s spending power, one that incorporates the Tenth Amendment’s reservation of certain powers to the states and prevents Congress from “employ[ing] the spending power in such a way as to ‘coerce’ the states into compliance with [a] federal objective,” should be added.⁴⁸ While the Eleventh Circuit recognized that there is a point where restrictions on a state’s ability to use grants of federal funding could be so burdensome as to prevent the state from having any real choice but to participate in “optional” federal programs and thus rise to the level of coercion,⁴⁹ the court decided that the ACA’s Medicaid expansion was not unduly coercive under relevant precedent.⁵⁰ *Florida ex. rel. Attorney General* was not, however, the end of the matter. Plaintiffs successfully petitioned the Supreme Court for certiorari, and the Court agreed to review the lower courts’ decisions as to the constitutionality of both the Medicaid expansion and the individual mandate.⁵¹

III. NATIONAL FEDERATION OF INDEPENDENT BUSINESS V. SEBELIUS

Although all circuit courts were in agreement that the Medicaid expansion did not amount to coercion, and “[n]o lower court had declared the Medicaid expansion unconstitutional,”⁵² the United States Supreme Court granted certiorari.

⁴⁷ *Id.* at 1268.

⁴⁸ *Florida ex. rel. Att’y Gen. v. U.S. Dep’t of Health and Human Servs.*, 648 F.3d 1235, 1264 (11th Cir. 2011), *aff’d in part, rev’d in part sub nom.* Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

⁴⁹ *Florida ex. rel. Att’y Gen.*, 648 F.3d at 1267.

⁵⁰ *Id.*

⁵¹ *See Fla. ex. Rel. Att’y Gen. v. Dep’t of Health and Human Servs.*, 648 F.3d 1235 (11th Cir. 2011), *cert granted*, 132 S. Ct. 604 (2011) (No. 11-400).

⁵² Nicole Huberfeld, Elizabeth Weeks Leonard & Kevin Outterson, *Plunging into Endless Difficulties: Medicaid and Coercion in National Federation of Independent Business v. Sebelius*, 93 B.U.L. REV. 1, 30 (2013).

A. *The States' Argument*

The States' argument against the Medicaid expansion focused heavily on the perceived need to limit Congress's spending power, as the Spending Clause is a means by which Congress can reach beyond its specifically enumerated powers.⁵³ According to the States, "if this Medicaid expansion [does] not cross the line into coercion, 'no Act of Congress ever will.'"⁵⁴ Thus, the States' challenges focused on the constitutionality of the expansion based on both the Spending Clause⁵⁵ and the Tenth Amendment.⁵⁶

B. *The United States's Argument*

The United States first argued for the Medicaid expansion's constitutionality by citing Congress's history of broad authority under the Spending Clause to "fix the terms on which it shall disburse federal money to the [S]tates."⁵⁷ The United States cited numerous instances where Congress has mandated expansions of categories of individuals and benefits covered by Medicaid.⁵⁸ The United States then challenged the logic of the states' coercion claim, which was based on the idea that the amount of federal funding that could be withheld from the states was so substantial as to leave the states with no choice but to participate in the expansion.⁵⁹ The United States noted that Petitioners' argument would support the peculiar proposition that the Medicaid expansion would have been more coercive if Congress had instead opted to indefinitely fund all of its costs.⁶⁰

⁵³ See Huberfeld, Leonard & Outterson, *supra* note 52, at 40–41 (citing *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2642 (2012) (Ginsburg, J., concurring in part and dissenting in part)) (recognizing that Congress has not unlimited spending power because of the power imbalance that can result from unlimited funding).

⁵⁴ Huberfeld, Leonard & Outterson, *supra* note 52, at 32–33 (quoting Reply Brief of State Petitioners on Medicaid at 10, *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012) (No. 11-393)). The states argued that the ACA is coercive since Congress threatened to withhold all federal Medicaid funding from states unwilling to participate in the expansion and did not provide states with an alternative means of insuring their low-income citizens.

⁵⁵ U.S. CONST. art. I, § 8, cl. 1.

⁵⁶ U.S. CONST. amend X.

⁵⁷ Brief for Respondents at 15, *Florida v. Dep't of Health & Human Services*, 132 S. Ct. 2566 (2012) (No. 11-400) (hereinafter Brief for Respondents).

⁵⁸ *Id.* at 26–27.

⁵⁹ Huberfeld, Leonard & Outterson, *supra* note 52, at 35.

⁶⁰ See Brief for Respondents, *supra* note 57, at 41 (arguing that had Congress decided to fund state Medicaid programs entirely, but conditioned their funding grant on expansion, the portion of funding withheld from non-expanding states would be im-

C. The Supreme Court's Plurality Opinion

On June 28, 2012, roughly two years after President Barack Obama signed the ACA into law, a plurality of the Supreme Court, led by Chief Justice John Roberts, found the Medicaid expansion to be unconstitutionally coercive.⁶¹

Chief Justice Roberts began his opinion by explaining that the Supreme Court has “long recognized that Congress may use [its power under the Spending Clause] to grant federal funds to the States, and may condition such a grant upon the States’ ‘taking certain actions that Congress could not [otherwise] require them to take.’”⁶² This power implies that Congress can monitor the states’ use of federal funds to make sure they “provide for the . . . general Welfare”⁶³ in the manner Congress intended when it granted states the funding.⁶⁴

Chief Justice Roberts then cautioned that the Court has recognized limits on Congress’s spending power when such power is used to secure state compliance with federal objectives, as “the Constitution has never been understood to confer upon Congress the ability to require the States to govern according to Congress’[s] instructions.”⁶⁵ If Congress’s spending power were not limited, federalism and thus individual liberty, could be compromised.⁶⁶

Chief Justice Roberts clarified that Spending Clause programs do not present a danger to federalism when states are given a legitimate choice whether to accept the federal conditions, so that holding state officials politically accountable for their decisions would be fair.⁶⁷ When, however, the state is left with no real choice but to accept the funding grant’s conditions, the federal government can avoid political accountability while still accomplishing goals it could not accomplish directly through employment of its enumerated powers.⁶⁸

mense and would, according to the states’ logic, be significantly more coercive than the terms of the ACA’s expansion).

61 See *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2601–08 (2012) (assessing the constitutionality of the ACA’s Medicaid expansion and finding it coercive, thereby violating the limits of the Spending Clause).

62 *Id.* at 2601 (quoting *College Sav. Bank v. Fla. Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 686 (1999)).

63 U.S. CONST. art. I, § 8, cl. 1.

64 See *Sebelius*, 132 S. Ct. at 2602.

65 *Id.* (internal citations omitted) (quoting *New York v. U.S.*, 505 U.S. 144, 162 (1992)).

66 See *Sebelius*, 132 S. Ct. at 2602.

67 *Id.*

68 See *id.* at 2603.

Applying this reasoning to the ACA's Medicaid expansion provision, the Court held that the threatened loss of over 20% of the average state's budget constituted the very threat to federalism that limits on Congress's spending power are necessary to prevent. Further, the United States's argument that the expansion is merely a modification of the existing Medicaid program, which the States agreed Congress could alter when they "signed on in the first place," was rejected.⁶⁹ Rather, the expansion "accomplishes a shift in kind, not merely degree" since the Medicaid program under the ACA was transformed into a program designed to meet the healthcare needs of all individuals earning below 133% of the FPL.⁷⁰ Thus, Medicaid "is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage."⁷¹

Finally, Chief Justice Roberts held that, while "Congress is not free . . . to penalize States that choose not to participate in [the] new program by taking away their existing Medicaid funding," the other reforms enacted by Congress under the ACA "will remain fully operative . . . and will still function in a way consistent with Congress's basic objectives in enacting the statute."⁷² This portion of the plurality opinion operated to save the ACA as a whole by rejecting the idea that the Medicaid expansion was necessary for the individual mandate to function.

While the Court may have saved the Patient Protection and Affordable Care Act as a whole, the designation of the Medicaid expansion as unconstitutional will likely operate to hamper the effectiveness of the Act. For the states that ultimately decide not to participate in the expansion, vulnerable citizens will be left without any means of obtaining affordable healthcare. Thus, low state participation in the expansion will directly counter the ACA's objectives and leave large gaps in healthcare coverage throughout the United States. Unless states are able to devise effective alternatives to expanding their Medicaid programs, the ACA's primary goal of providing quality healthcare to all Americans will likely prove infeasible.

⁶⁹ *Id.* at 2605.

⁷⁰ *Id.* at 2606.

⁷¹ *Id.*

⁷² *Id.* at 2607-08.

III. ALTERNATE STATE PLANS

As of February 18, 2015, twenty-nine states and the District of Columbia had decided to participate in the ACA's Medicaid expansion.⁷³ Fifteen states had declined to participate, and seven states—Alaska, Missouri, Montana, Tennessee, Utah, Virginia, and Wyoming—are presently undecided.⁷⁴ Unfortunately, many of the states that have decided not to expand Medicaid are amongst the least generous in terms of their Medicaid eligibility requirements.⁷⁵

For seventeen states, most of which have decided not to participate in the expansion, Medicaid eligibility levels for parents with dependent children were set at or below 50% of the FPL.⁷⁶ In another seventeen states that have also largely declined participation or are undecided eligibility levels for parents with dependent children were set below 100% of the FPL.⁷⁷ And, in almost all of these states, enrollees must belong to certain categorical groups to be eligible for Medicaid.⁷⁸ Thus, childless adults without disabilities are almost entirely ineligible for Medicaid's assistance.

There may, however, be a viable alternative to expanding Medicaid according to the ACA's terms. This alternative, which a handful of states have pursued, involves negotiation with the federal government so that states can use Medicaid funding to provide healthcare to their low-income citizens without enrolling them directly in Medicaid.⁷⁹ This Part seeks to examine the select group of states that have decided to provide healthcare for low-income citizens on terms that are different from those of the ACA's Medicaid expansion.

As of February 18, 2015, Arkansas, Indiana, Iowa, Michigan, and Pennsylvania have all proposed using federal Medicaid funds to pur-

⁷³ *Status of State Action on the Medicaid Expansion Decision*, KAISER FAMILY FOUND., <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/> (last visited Feb. 13, 2015).

⁷⁴ *Id.*

⁷⁵ See generally ANNETTE B. RAMIREZ DE ARELLANO & SIDNEY M. WOLFE, PUB. CITIZEN HEALTH RESEARCH GRP., UNSETTLING SCORES: A RANKING OF STATE MEDICAID PROGRAMS 19 (2007), available at <http://www.citizen.org/documents/2007UnsettlingScores.pdf>.

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ MaryBeth Musumeci, *Medicaid Expansion Through Marketplace Premium Assistance*, KAISER FAMILY FOUND. (Sept. 17, 2013), <http://kff.org/medicaid/fact-sheet/medicaid-expansion-through-marketplace-premium-assistance/> (explaining that premium assistance proposals are a means by which states can retain federal Medicaid funding, but use such funding to provide private health insurance to newly eligible Medicaid enrollees under the ACA).

chase private coverage for individuals who would be newly eligible for Medicaid under the ACA.⁸⁰ All of these states have had their § 1115 demonstration waivers⁸¹ approved by the Centers for Medicare and Medicaid Services, but Pennsylvania's newly elected governor may opt for a state plan amendment.⁸² The Arkansas, Iowa, and Pennsylvania plans are discussed more fully in the following Parts. The alternate plans of Indiana and Michigan, while containing some differences, are substantially similar to the state plans described below.

A. *The Arkansas Plan*

On September 27, 2013, the Centers for Medicare and Medicaid Services notified Arkansas state officials that it had approved Arkansas' alternate expansion plan.⁸³ Arkansas applied for a § 1115 waiver so that the roughly 200,000 Arkansas citizens who became eligible for Medicaid under the ACA could purchase individual plans from the healthcare marketplace, rather than being enrolled in the state's Medicaid program.⁸⁴

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services "wide latitude"⁸⁵ to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance programs.⁸⁶ Spe-

⁸⁰ Robin Rudowitz, Samantha Artiga & MaryBeth Musumeci, *The ACA and Recent Section 1115 Medicaid Demonstration Waivers*, KAISER FAMILY FOUND., <http://kff.org/medicaid/issue-brief/the-aca-and-recent-section-1115-medicaid-demonstration-waivers/> (last visited Feb. 15, 2015).

⁸¹ *Section 1115 Demonstrations*, *supra* note 20 (explaining that "Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches.").

⁸² Robin Rudowitz, Samantha Artiga, and Marybeth Musumeci, *The ACA and Medicaid Expansion Waivers*, KAISER FAMILY FOUND., <http://kff.org/medicaid/issue-brief/the-aca-and-medicaid-expansion-waivers/> (last visited Mar. 27, 2015); Kate Giammarise, *Wolf Begins Dismantling Healthy PA in Favor of Medicaid*, PITTSBURGH POST-GAZETTE (Feb. 9, 2015), <http://www.post-gazette.com/local/region/2015/02/09/Wolf-announces-plans-to-revamp-states-Medicaid-plan/stories/201502090152>.

⁸³ Sarah Kliff, *Arkansas is Using This Weird Trick to Expand Medicaid*, WASH. POST WONKBLOG (Sept. 27, 2013), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/09/27/arkansas-is-using-this-weird-trick-to-expand-medicaid/>.

⁸⁴ *Id.*

⁸⁵ Theodore W. Ruger, *Health Policy Devolution and the Institutional Hydraulics of the Affordable Care Act*, in *THE HEALTHCARE CASE: THE SUPREME COURT'S DECISION AND ITS IMPLICATIONS*, 367 (Nathaniel Persily, Gillian E. Metzger & Trevor W. Morrison eds., 2013).

⁸⁶ *Section 1115 Demonstrations*, *supra* note 20.

cifically, § 1115 provides that “the Secretary may waive compliance with any of the requirements of [the Act] to the extent and for the period he finds necessary to enable a state to carry out any experimental, pilot, or demonstration project which the Secretary believes is likely to assist in promoting the objectives of the Act.”⁸⁷ These § 1115 demonstrations must be budget-neutral so that federal Medicaid expenditures do not exceed federal spending absent the waiver.⁸⁸ In Arkansas, the alternate expansion program is not expected to cost the federal government any more than a traditional expansion, and the alternate program is set to continue for three years.⁸⁹ When the agreement expires, either the Centers for Medicaid and Medicare Services (“CMS”) or Arkansas can decide whether it would like to renew the premium assistance program.⁹⁰

The Arkansas plan will cover all newly eligible Medicaid beneficiaries between the ages of nineteen and sixty, parents earning between 17% and 138% of the FPL, and childless adults earning between 0% and 138% of the FPL.⁹¹ For these individuals, enrollment in the premium assistance program will be mandatory.⁹²

The medically frail⁹³ will be exempt from the program but may opt in if they choose.⁹⁴ Under the Arkansas plan, wraparound benefits, which supplement private insurance plans that offer fewer bene-

87 Ruger, *supra* note 85 (internal quotations omitted).

88 See Musumeci, *supra* note 79 (discussing the requirement of cost-effectiveness in premium assistance programs).

89 *Id.*

90 Kliff, *supra* note 83.

91 See Musumeci, *supra* note 79, at Fig. 2 (showing the eligible Medicaid beneficiaries for the Arkansas plan); *Medicaid Expansion in Arkansas*, KAISER FAMILY FOUND., <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-arkansas/> (last visited Mar. 28, 2015).

92 See Musumeci, *supra* note 79 (explaining that because Arkansas and the other states following the premium assistance model have made enrollment mandatory, 1115 waivers are necessary before the plans can be implemented).

93 See 42 C.F.R. § 440.315(f) (2013) (allowing the states to define medically frail but mandating that the category include “children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living”); see also KRISTEN JENSEN & NANCY KIRCHNER, CTRS. FOR MEDICARE & MEDICAID SERVS., *MEDICAID HIGHLIGHTS OF THE FINAL RULE: ALTERNATIVE BENEFIT PLANS AND ESSENTIAL HEALTH BENEFITS* 11 (July 9, 2013), available at <http://www.medicare.gov/State-Resource-Center/Eligibility-Enrollment-Final-Rule/Alternative-Benefit-Plans-and-Essential-Health-Benefits.pdf> (explaining that people with substance abuse disorders are included in the definition of medically frail).

94 See Musumeci, *supra* note 79 (explaining how the medically frail will be exempt from the program unless they opt in).

fits than Medicaid, will be provided on a fee-for-service basis.⁹⁵ Further, Arkansas anticipates developing a pilot project with health savings accounts for new beneficiaries in 2015 and 2016.⁹⁶ The state also plans to amend its waiver to extend coverage to parents earning less than 17% of the FPL, and to children, by the year 2016.⁹⁷

Individuals who qualify for Arkansas's premium assistance plan will be able to choose between at least two "high value silver level" quality health plans in the marketplace.⁹⁸ If qualified individuals do not choose a plan, one will be assigned to them, and automatically assigned enrollees will then have thirty days to change their plan.⁹⁹ Automatic assignment will be based on "target minimum market shares" of beneficiaries in each quality health program in the applicable region.¹⁰⁰

Arkansas will pay monthly premiums directly to the quality health plans for premium assistance enrollees, and beneficiaries will not be responsible for any premium costs.¹⁰¹ Beneficiaries will, however, be responsible for cost sharing of up to 5% of their annual income.¹⁰² For beneficiaries earning between 100% and 138% of the FPL, cost-sharing will be consistent with Medicaid and marketplace quality health plan rules.¹⁰³ There will be no cost-sharing for beneficiaries earning below 100% of the FPL in 2014, but Arkansas's waiver application indicates that cost-sharing for individuals earning between 50% and 100% of the FPL will be introduced in 2015 and 2016.¹⁰⁴

There will be no cost sharing for individuals who are exempted under federal Medicaid law.¹⁰⁵ Individuals enrolled in a quality health plan under Arkansas's premium assistance program will receive health benefits identical to those received by Arkansas citizens enrolled in the state's Medicaid program.¹⁰⁶

95 *Id.*

96 *Id.*

97 *Id.*

98 *Id.*

99 *See id.* (describing the amount of time that automatic enrollees will have to change their plans).

100 *Id.*

101 *Id.*

102 *Id.*

103 *Id.*

104 *See id.* (stating timing of when costs haring will take place for certain the poverty level categories).

105 *Id.*

106 *Id.*

B. *The Iowa Plan*

Iowa's § 1115 waiver was approved on December 10, 2013.¹⁰⁷ The state's premium assistance plan will cover newly eligible Medicaid beneficiaries earning between 100% and 138% of the FPL who do not have cost-effective employer-sponsored insurance.¹⁰⁸ Beneficiaries earning up to 100% of the FPL will be covered through Medicaid managed care arrangements approved under another § 1115 demonstration.¹⁰⁹ As in Arkansas, enrollment in a quality health plan will be mandatory for all § 1115 demonstration beneficiaries with an exception for the medically frail.¹¹⁰ American Indians and Alaskan natives can also voluntarily opt-out of the premium assistance program.¹¹¹

Premium assistance beneficiaries will choose between at least two silver level plans in the healthcare marketplace and may choose from all silver plans available in their geographic region.¹¹² Further, the § 1115 waiver quality health plans must offer 100% actuarial value.¹¹³ This means that the plan must cover 100% of an enrollee's healthcare expenses, even though silver plans for individuals not eligible to participate in Iowa's premium assistance program will have an actuarial value of only 70%.¹¹⁴ Once enrolled in a quality health plan, premium assistance enrollees must remain enrolled for twelve months.¹¹⁵

Unlike beneficiaries in Arkansas, who pay no premiums, all premium assistance beneficiaries in Iowa will pay monthly premiums that cannot exceed 2% of their annual household income.¹¹⁶ These premiums "will be waived for the first year of enrollment and may be waived in subsequent years if beneficiaries complete specified 'health improvement activities.'"¹¹⁷ Beneficiaries will have a ninety-day grace period to pay past-due premiums before Medicaid eligibility will be

107 *Id.*

108 *Id.*

109 *See id.* (stating a category of individuals that will be covered through the Medicaid managed care arrangement).

110 *Id.*

111 *Id.*

112 *Id.*

113 *Id.*

114 *Focus on Health Reform: What the Actuarial Values in the Affordable Care Act Mean*, KAISER FAMILY FOUND. (April 2011), <http://kff.org/health-reform/issue-brief/what-the-actuarial-values-in-the-affordable/> (describing actuarial values for different tiers of coverage, including a silver plan with a 70% actuarial value).

115 *See Musumeci, supra* note 79 (stating the amount of time that premium assistance enrollees must remain enrolled).

116 *Id.*

117 *Id.*

terminated.¹¹⁸ As in Arkansas, there will be cost sharing for beneficiaries limited to 5% of annual income.¹¹⁹ There will also be copays for Iowa beneficiaries who rely on emergency rooms for non-emergency purposes.¹²⁰

The benefits provided to premium assistance enrollees must “be at least equivalent to state employee plan benefits package[s].”¹²¹ Further, in Iowa, dental benefits will be provided to enrollees “through a capitated commercial dental plan carve-out.”¹²²

C. *The Proposed Pennsylvania Plan*

Former Pennsylvania Governor Thomas Corbett submitted a § 1115 waiver application on February 19, 2014.¹²³ The proposal, which spans over 100 pages, was approved on August 28, 2014.¹²⁴ Pennsylvania’s demonstration, like the approved § 1115 waiver programs in Arkansas, Iowa, Indiana, and Michigan, would use federal funds to cover citizens through the marketplace created under the ACA rather than expanding state Medicaid rolls.¹²⁵ The “Healthy Pennsylvania”¹²⁶ plan would cover all newly eligible Medicaid beneficiaries between the ages of twenty-one and sixty-four and all parents earning between 33% and 138% of the FPL.¹²⁷ Newly eligible nineteen and twenty year olds would be covered through Medicaid managed care.¹²⁸ The plan provides essential health benefits based on the small group plan with the largest enrollment benchmark.¹²⁹

As in Arkansas and Iowa, enrollment in private health insurance is mandatory for all Pennsylvania citizens who qualify, with the medically frail being exempt.¹³⁰ There is also an additional eligibility re-

118 *Id.*

119 *Id.*

120 *Id.*

121 *Id.*

122 *Id.*

123 Pa. Dep’t of Pub. Welfare, Medical Assistance Bulletin (Nov. 4, 2014), *available at* http://www.dpw.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/c_116644.pdf.

124 Pa. Dep’t of Pub. Welfare, Healthy Pennsylvania 1115 Demonstration Application (Feb. 2014), *available at* http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/c_071204.pdf.

125 *See* Musumeci, *supra* note 79.

126 Thomas Corbett, Healthy PA: Access, Affordability, Quality (Apr. 3, 2014), *available at* <http://www.pennsylvaniaoralhealth.org/important-articles-pages/2014/4/3/healthy-pa-access-affordability-quality>.

127 *See* Musumeci, *supra* note 79.

128 *Id.*

129 *Id.*

130 *Id.*

quirement in Pennsylvania mandating that all “able-bodied” adults register with the Pennsylvania Department of Labor and actively engage in work search or job training activities.¹³¹ Furthermore, in order to maintain Medicaid eligibility, enrollees are required to complete twelve approved work search activities during the first six months of enrollment.¹³² The approved Healthy Pennsylvania plan includes premiums for enrollees on an income-based sliding scale.¹³³ The premiums can, however, be reduced by a maximum of 50% if enrollees engage in certain “healthy behavior and work search activities.”¹³⁴ Enrollees in the Healthy Pennsylvania plan face termination of benefits if premiums remain unpaid for three consecutive months.¹³⁵ Cost sharing is also required for all non-emergency use of the emergency room.¹³⁶

IV. EVALUATION

The premium assistance plans will likely provide non-expanding states with the same benefits realized by expanding states, while still furthering the objectives of the ACA. Although the Arkansas, Iowa, Indiana, Michigan, and Pennsylvania plans are not technically Medicaid expansions, since individuals will be directed to the marketplace rather than enrolled directly in Medicaid, the overall effect on health insurance coverage will be substantially the same.

For states like Tennessee and Wyoming, which view the ACA's Medicaid expansion as politically infeasible, but are looking for ways to provide healthcare to the vulnerable residents, the premium assistance plans may be a viable option.¹³⁷ The market-based premium assistance plans have a much greater degree of acceptance among Republican lawmakers who oppose expanding traditional Medicaid programs but are willing to pursue a free-market approach to healthcare.¹³⁸ Further, since CMS has already demonstrated a willingness to allow states to experiment with premium assistance plans through § 1115 waivers, such plans may be the only way to ensure that

131 *Id.*

132 *Id.*

133 *Id.*

134 *Id.*

135 *Id.*

136 *Id.*

137 Christine Vestal, *More States Lean Toward Medicaid Expansion*, HUFFINGTON POST (Jan. 28, 2015), http://www.huffingtonpost.com/2015/01/28/states-medicaid-expansion_n_6563586.html.

138 See *Premium Assistance in Medicaid*, HEALTH AFFAIRS (June 6, 2013), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=94.

vulnerable populations obtain health coverage in states opposed to the ACA's expansion.¹³⁹

The premium assistance plans also have benefits beyond political acceptance by conservative lawmakers.¹⁴⁰ First, since the plans provide newly eligible beneficiaries with commercial insurance, plan enrollees may have access to primary care physicians, specialists, and hospitals that do not participate in the Medicaid program.¹⁴¹ Further, providing commercial health coverage rather than coverage through Medicaid "could allow people whose incomes fluctuate to more easily move from full Medicaid to a federally subsidized policy."¹⁴² "Currently, many patients face gaps and variation in their coverage as changes in their income force them in and out of Medicaid and the private insurance market."¹⁴³

A study done by George Washington University found that individuals who retained Medicaid coverage for a year paid approximately \$333 a month in Medicaid bills.¹⁴⁴ Patients who remained covered for only one month, however, paid roughly \$625 a month.¹⁴⁵ Thus, in the absence of continuity of coverage, individuals are "less likely to get the preventive care and chronic disease management they need to stay healthy and keep costs down."¹⁴⁶ Under a premium assistance model, the same carrier may offer Medicaid and commercial health coverage plans with the same network of doctors and hospitals.¹⁴⁷ Thus, the discontinuity of care that can lead to increased costs could be largely eliminated. Such an approach can also lead to administrative savings for states since individuals will not need to enroll in a plan with a different provider network if their income rises.¹⁴⁸

Finally, commercial coverage for newly eligible enrollees could "jumpstart competition among commercial insurance carriers and give states more sway over these companies and medical providers

139 *Id.*

140 Christine Vestal, *Obama Administration Poised to Approve Arkansas-Style Medicaid Expansions*, PEW CHARITABLE TRUSTS STATELINE (May 6, 2013), <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2013/05/06/obama-administration-poised-to-approve-arkansas-style-medicaid-expansions>.

141 *Id.*

142 *Id.*

143 *Premium Assistance in Medicaid*, *supra* note 138, at 5.

144 *Id.*

145 *Id.*

146 *Id.*

147 *See id.* ("If Medicaid beneficiaries can enroll in an exchange plan up front, they won't have to move into a plan with a different provider network if their income rises.")

148 *Id.*

who serve Medicaid patients and other low-income adults.”¹⁴⁹ This is because the new exchanges may be able to “aggregate the purchasing power of individuals and small groups and extend system reforms beyond Medicaid.”¹⁵⁰

These premium assistance plans may not, however, be cost effective for participating states initially. The Congressional Budget Office estimated that providing Medicaid coverage to the newly insured would “cost about \$6,000 per year per person.”¹⁵¹ Commercial insurance coverage, purchased through the healthcare marketplace, will cost almost \$9,000 per person on average.¹⁵²

Since the federal and state governments pay providers directly under traditional Medicaid programs and have a large network with which they can negotiate fees, private insurers traditionally pay providers much more than Medicaid for services.¹⁵³ Since the § 1115 waivers mandate that the premium assistance demonstration models not cost the federal government more than traditional Medicaid programs,¹⁵⁴ premium assistance states will be paying more to provide coverage for newly eligible Medicaid beneficiaries than states participating in the ACA’s expansion directly.¹⁵⁵

However, as the share of the expansion funding granted to the states by the federal government is reduced and predicted cost shifts are realized, the premium assistance plans may become more comparable to the ACA’s Medicaid expansion.¹⁵⁶ The overall cost of private insurance and Medicaid are predicted to converge over time under the ACA as “[i]nsurance companies interested in competing for newly eligible Medicaid beneficiaries and for low-income individuals purchasing policies on the exchange may be willing to lower their prices.”¹⁵⁷ The addition of millions of individuals to the Medicaid program may also force states to increase the rates they pay healthcare providers “to convince more doctors, dentists, pharma-

149 Vestal, *supra* note 140.

150 *Premium Assistance in Medicaid*, *supra* note 138, at 4.

151 *Id.*

152 *Id.*

153 Edwin Park, *Expanding Medicaid a Less Costly Way to Cover More Low-Income Uninsured Than Expanding Private Insurance*, CTR. ON BUDGET & POLICY PRIORITIES (June 26, 2008), <http://www.cbpp.org/cms/?fa=view&id=429>.

154 *See* Musumeci, *supra* note 79 (detailing federal restrictions on costs and premium imposition).

155 *See* Park, *supra* note 153 (describing the cost savings of the ACA relative to Medicaid through lower reimbursement rates and reduced administrative costs).

156 *See* Vestal, *supra* note 140 (describing the possibility of increased state costs as contributions increase).

157 *Id.*

cists, and hospitals to serve the new patients.”¹⁵⁸ Further, before these predicted changes take place, premium assistance states might be able to “offset cost increases with savings that may come when people can more easily move from Medicaid to subsidized insurance on the exchange.”¹⁵⁹ Increased competition may also act to lower costs as more individuals purchase insurance on the marketplace.¹⁶⁰

The question of states’ premium assistance models’ workability beyond their respective trial periods still remains. As per the terms of the ACA, the federal government will begin reducing its contribution to expanded state Medicaid programs after three years.¹⁶¹ Federal approval of any § 1115 waiver requires that demonstration models not cost the federal government more than traditional Medicaid programs.¹⁶²

Therefore, states may have trouble renewing their premium assistance agreements once federal funding contributions to the expanding states drops below 100%. If the cost saving predictions are realized,¹⁶³ and private insurance costs begin converging with the cost of Medicaid, continuation of state premium assistance models will likely be feasible. If such predictions are inaccurate or slow to occur,¹⁶⁴ the models will likely need to be reconsidered as states may be financially unable to continue using the reduced federal subsidies to purchase private insurance for their low-income, newly Medicaid eligible citizens.

Another concern regarding the premium assistance models is that the alternate approach does not necessarily mean that low-income individuals will obtain benefits equivalent to those they would have received if enrolled in a traditional Medicaid program.¹⁶⁵ The ACA

158 *Id.*

159 *Id.*

160 *See id.* (“The agency [HHS] also told states that increased competition in exchanges would occur because of the newly eligible enrollees, and that could result in lower prices.”).

161 42 U.S.C. § 1396d(y)(1) (prescribing that the federal government will reduce its contribution to 95% for calendar quarters in 2017, 94% for calendar quarters in 2018, 93% for calendar quarters in 2019, and 90% for calendar quarters in 2020 and into future years).

162 *See Musumeci, supra* note 79 (finding that premium assistance programs must be “cost-effective” as compared to the Medicaid state plan).

163 *See Vestal, supra* note 140 (“Experts say, however, that the costs of private insurance and Medicaid are likely to converge over time.”).

164 *See id.*

165 Stanton R. Mehr & Mary K. Caffrey, *New Approaches to Medicaid Expansion: Hybrid Plans Offer Alternatives for Covering More People*, AM. J. MANAGED CARE (Dec. 16, 2013), <http://www.ajmc.com/publications/ebrc/2013/novdecem13/new-approaches-to-medicaid-expansion-hybrid-plans-offer-alternatives-for-covering-more-people>.

mandates that certain essential benefits be provided to all Medicaid enrollees, but states using premium assistance models are not adding citizens to their Medicaid roles. CMS has, however, addressed this issue in both Arkansas and Iowa by requiring that those states provide a form of “wrap around” coverage to ensure that citizens receiving coverage under the premium assistance models obtain the same benefits as an individual enrolled in Medicaid.¹⁶⁶ Furthermore, CMS has required that enrollees under a premium assistance model be given a choice between at least two silver plans in the marketplace.¹⁶⁷ The question of adequacy of coverage is, therefore, unlikely to be an issue should other states decide to create their own premium assistance models, as CMS has already expressed its unwillingness to approve plans that offer enrollees fewer benefits than they would receive under a traditional Medicaid program.¹⁶⁸

Although Medicaid benefit packages can vary tremendously from state to state, as the use § 1115 waivers in the past has led to variations in basic state Medicaid benefit packages,¹⁶⁹ evidence from Arkansas and Iowa shows that CMS will likely prevent premium assistance models from acting to further increase benefit discrepancies among states. The Department of Health and Human Services has also been working with states to add additional premium payments to exchange plans so that states pursuing a premium assistance model can simply add on the required services to the traditional exchange package of benefits.¹⁷⁰ This will allow states to comply more easily with § 1115 waiver requirements.

V. STATES NOT EXPANDING

While there may be both expected and unexpected difficulties surrounding Arkansas, Iowa, Indiana, Michigan, and Pennsylvania’s premium assistance plans, these states, along with those that have decided to expand their Medicaid programs in accordance with the ACA, will have their most vulnerable citizens insured. For states that

¹⁶⁶ *Id.*

¹⁶⁷ See Park, *supra* note 153 (“Beneficiaries choose between at least two silver level Marketplace QHPs and may choose among all silver plans available in geographic region.”).

¹⁶⁸ *Medicaid Expansion Through Premium Assistance: Arkansas, Iowa, and Pennsylvania’s Proposals Compared*, KAISER FAMILY FOUND. (Apr. 2014), <https://kaiserfamilyfoundation.files.wordpress.com/2014/04/8463-04-medicaid-expansion-through-premium-assistance-arkansas-iowa-and-pennsylvania.pdf>.

¹⁶⁹ See Ruger, *supra* note 85, at 367 (detailing the vast number of such waivers in the 1990s and 2000s from the perspective of the federal government).

¹⁷⁰ *Premium Assistance in Medicaid*, *supra* note 138.

have chosen not to participate in the expansion and have no plans to develop their own premium assistance models, hundreds of thousands of state citizens will remain without sufficient health insurance.¹⁷¹

As previously noted, this substantial gap in coverage could greatly reduce the effectiveness of the ACA. In non-expanding states, the poorest adults would remain covered by Medicaid, but to significantly variable degrees of eligibility.¹⁷² Some states, for example, provide Medicaid coverage for adults only up to 17% of the FPL while other states provide coverage up to, and in some states beyond, 133%.¹⁷³ These significant “donut hole” gaps will make universal coverage nearly impossible, as the poorest citizens are statutorily exempt from the individual mandate and without the financial means to purchase health insurance on the marketplace.¹⁷⁴

Further, the ACA provides that only individuals earning between 100% and 400% of the FPL will be eligible for tax credits if they purchase health insurance through the marketplace.¹⁷⁵ For states with the least generous income thresholds for pre-ACA Medicaid eligibility, a significant portion of poor citizens will be left “with neither a government healthcare program nor government assistance to purchase private health insurance.”¹⁷⁶ This gap will undoubtedly raise questions of equity and fairness, as similarly situated individuals in different states receive widely disparate treatment in terms of healthcare availability.

It might be argued that individuals left without health coverage in non-expanding states could petition their state-elected officials or use the political process to elect new representatives. Federalism’s political accountability may, however, be lost due to the ACA’s blend of federal and state involvement in the Act’s implementation.¹⁷⁷ Thus, citizens in non-expanding states may place the blame for their lack of coverage on the federal government rather than the state officials

171 See FOCUS ON HEALTH REFORM, *supra* note 19.

172 See Ruger, *supra* note 85 (stating that § 1115 of the Social Security Act allows for such varying degrees of eligibility among the states).

173 See generally RAMIREZ DE ARELLANO & WOLFE, *supra* note 75.

174 See Huberfeld et al., *supra* note 52 at 85 (finding that the “donut hole” exists in light of the Supreme Court declaring that the Medicaid expansion under the Affordable Care Act was unconstitutional).

175 See 26 U.S.C.A. § 36(B).

176 Huberfeld, Leonard & Outtersen, *supra* note 52, at 86.

177 See *id.* (“One apparent political goal of the tax-credit challenge is to deny coverage to millions of additional people, while laying the blame for ACA’s failures on the federal tax code rather than state officials who opt out of Medicaid expansion or a state exchange.”).

who elected to opt-out of the Medicaid expansion. Low-income citizens in non-expanding states may, therefore, become even more exposed than they were prior to the ACA's implementation and have no real means of expressing their grievances through the political process.¹⁷⁸

Non-expanding states may also face serious financial detriments for declining to participate in the expansion. First, federal taxes taken from states that have decided not to expand Medicaid will be used to fund the expansion in other states.¹⁷⁹ A study done by the Commonwealth Fund found that every state that does not participate in the Medicaid expansion would see a net loss in federal funds by the year 2022.¹⁸⁰ For example, if Texas ultimately decides not to participate in the Medicaid expansion, the state will forgo "an estimated \$9.58 billion in federal funding by 2022."¹⁸¹ When the amount of federal taxes paid by Texas residents is taken into account, "the net cost to taxpayers in the state in 2022 will be more than \$9.2 billion."¹⁸² Similarly, Florida taxpayers would lose more than five billion dollars, Georgia taxpayers nearly \$4.9 billion and South Dakota taxpayers approximately \$224 million.¹⁸³ The citizens in non-expanding states will, therefore, be paying taxes without receiving any of the benefits that states participating in the expansion, or a premium assistance plan, receive.

Increases in federal funding also create direct benefits by bolstering state economies and providing the means necessary for betterment projects.¹⁸⁴ Thus, even if a given state does not value "the health and health system benefits" of expanding Medicaid, the state should value the expansion "as a source of [funding] that benefits the state's economy."¹⁸⁵

Further, hospitals in states that have decided not to expand will lose federal funding meant to offset the cost of treating uninsured patients, since all citizens were expected to gain health insurance un-

178 *See id.* (Noting that under the ACA, "low-income individuals in Medicaid opt-out states with federal exchanges will be even more exposed").

179 *See* Sherry Glied & Stephanie Ma, *How States Stand to Gain or Lose Federal Funds by Opting In or Out of the Medicaid Expansion*, COMMONWEALTH FUND 1, 2 (Dec. 2013).

180 *See id.* at 4 ("In every case, choosing not to participate in the [Medicaid] expansion [under the ACA] generates a net loss of federal funds.").

181 *Id.*

182 *Id.*

183 *Id.*

184 *See id.* at 3 (arguing that such funds provide greater flexibility in state budgets by subsidizing Medicaid costs and allowing that money to be spent on other public works projects).

185 *Id.*

der the ACA. These Disproportionate Share Hospital (“DHS”) programs, which pay out about \$22 billion annually, will be reduced by nearly \$18.1 billion between 2014 and 2020.¹⁸⁶ Low-income individuals, who are statutorily exempt from the individual mandate, will remain uninsured absent affordable state subsidized health insurance, and remain the “primary beneficiaries of uncompensated hospital care.”¹⁸⁷ This means that “hospitals in non-expansion states . . . could face substantial erosion of DSH funds despite seeing little or no change in the amount of uncompensated care they provide.”¹⁸⁸ To recoup the loss of DSH funds, “hospitals could seek to . . . [limit] . . . uncompensated care or, most likely, pass nontrivial costs on to the privately insured.”¹⁸⁹ Thus, non-expanding states will likely leave a significant uncompensated-care burden on hospitals.

VI. IMPLICATIONS FOR THE FUTURE AND “FEDERALISM BY WAIVER”

As the preceding Part articulates, § 1115 waivers can clearly benefit both the federal and state governments. In fact, the overall success of the ACA’s Medicaid expansion may depend on negotiations between state and federal actors. However, the implications of this system of “federalism by waiver”¹⁹⁰ reach far beyond the provisions of the ACA. Many scholars debate the propriety of allowing states to negotiate the terms of cooperative spending programs and it is clear that this debate will only increase in the wake of *Sebelius*. *National Federation of Independent Business v. Sebelius* represents the first time the Supreme Court has struck down federal legislative action taken pursuant to the Spending Clause on Tenth Amendment grounds.¹⁹¹ Previously, the Court has made “little effort . . . to protect the states when Congress uses its power under the Spending Clause to influence state affairs.”¹⁹² This is likely due to the fact that federal legislatures could “point to the state’s voluntary decision to accept the funds” as indica-

186 See James A. Graves, *Medicaid Expansion Opt-Outs and Uncompensated Care*, 367 NEW ENG. J. MED. 2365, 2365 (2012), available at <http://www.nejm.org/doi/full/10.1056/NEJMp1209450>.

187 See *id.* at 2366.

188 *Id.*

189 *Id.* at 2367.

190 See Samuel R. Bagenstos, *The Healthcare Case: The Supreme Court’s Decision and Its Implications*, (University of Michigan Public Law and Legal Theory Research Paper Series, Paper No. 294, 2012), available at <http://ssrn.com/abstract=2161599>.

191 See *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012) (holding that the Medicaid expansion under the Affordable Care Act is unconstitutional).

192 Note, *Federalism, Political Accountability, and the Spending Clause*, 107 HARV. L. REV. 1419, 1420 (1994).

tive of the states' acceptance of federal legislative action.¹⁹³ The *Sebelius* Court, as previously noted, found the states' ability to make a "voluntary decision" lacking under the ACA's Medicaid expansion and therefore held that the provision was unconstitutionally coercive.¹⁹⁴ The Supreme Court's attempt to safeguard the federal model protected under the Tenth Amendment may, however, have unforeseen consequences for joint federal and state programs as waiver applications rise. The *Sebelius* holding is likely to provide states with significantly greater bargaining power in the realm of cooperative federal-state programs due to an increase in waiver applications.¹⁹⁵ In fact, the § 1115 waivers that have been approved, or are being considered, by CMS provide a clear example of increased state leverage when negotiating with the federal government.

When, as with the ACA's Medicaid expansion,¹⁹⁶ "federal funding conditions are phrased in highly discretionary terms," an administration can be expected to grant more waivers—especially when such waivers "serve [the administration's] substantive policy preferences."¹⁹⁷

An administration's policy preferences are not, however, the only crucial variable.¹⁹⁸ Each waiver granted by the federal government stems from "an iterative, negotiated process, in which the state holds a number of important cards."¹⁹⁹ In fact, states have the major advantage of being able to opt out of a federal program entirely if the federal government declines to negotiate or waive rules the states find objectionable.²⁰⁰ Thus, federal officials will be inclined to grant state waivers so that as much of cooperative programs as possible can be salvaged.

There are, however, concerns over the desirability of this "waiver regime." First, there is a concern that the waivers will lead to a rise in "picket fence federalism."²⁰¹ Further, some liberal critics believe that

193 *Id.*

194 *Sebelius*, 132 S. Ct. at 2635.

195 See Ruger, *supra* note 85, at 369 ("[W]aivers offered motivated states the chance to bargain for policy discretion and simultaneously obtain a more generous financial deal from the federal underwriter.").

196 See *id.* at 366–69 (explaining that, for the expanded Medicaid program, the federal government acts primarily as fiscal underwriter and broad standard-setter, leaving much discretion and responsibility for implementation to the states).

197 Bagenstos, *supra* note 190, at 4.

198 See *id.* at 5.

199 *Id.*

200 See *id.*

201 Roderick M. Hills, Jr., *The Eleventh Amendment as a Curb on Bureaucratic Power*, 53 STAN. L. REV. 1225, 1227 (2001) (explaining that the idea behind picket fence federalism is "that

the waivers will lead to statutory erosion.²⁰² There are, however, many advantages to this phenomenon of “federalism by waiver,” and despite real concerns, the practical benefits of waivers are likely to outweigh the costs.²⁰³

A. Criticisms

The first concern stemming from a rise in waiver applications is that state officials with the power to negotiate waivers will not be “policy generalists” elected by state citizens, but rather expert-bureaucrats who specialize in relevant policy arenas, a phenomenon known as “picket fence federalism.”²⁰⁴ It has been suggested that this form of federalism is undesirable because of its potential to undermine “comprehensive, cross-program planning and budgeting”²⁰⁵ and “the power of [democratically] elected policy generalists . . . to control state and local government.”²⁰⁶ The fear is that waivers, such as the recently proposed § 1115 Medicaid waivers detailed above, could encourage the formation of alliances between “federal- and state-level subject-matter expert bureaucrats, who join together to overcome resistance to a federal program’s goals from politicians²⁰⁷ and generalist agency officials at the state level.”²⁰⁸ Furthermore, many liberal critics of the waiver regime claim that the waivers have undermined, and will continue to, “undermine hard-won statutory requirements that would otherwise bind states to provide important services to less privileged and empowered individuals and communities.”²⁰⁹ Critics argue further that states may attempt to use waivers to reduce spending on cooperative programs created to protect vulnerable populations dur-

state and federal agency experts within the same specialty—the ‘posts’ in the ‘fence’—often share more in common with each other than they do with the level of government by which they are employed”).

202 See Bagenstos, *supra* note 190, at 9.

203 *Id.*

204 Hills, *supra* note 201.

205 *Id.* at 1238 (describing the potential of picket fence federalism to lead to “piecemeal policy-making by bureaucratic fiefdoms . . . without any coordination and prioritization of the various policies across different areas of policy specialization”).

206 *Id.* at 1240.

207 Such politicians include governors, state legislators, mayors, city councillors, and county commissioners. *Id.*

208 Samuel R. Bagenstos, *Federalism by Waiver after the Helathcare Case*, in *THE HELATHCARE CASE: THE SUPREME COURT’S DECISION AND ITS IMPLICATIONS* 232 (Nathaniel Persily, Gillian E. Metzger & Trevor W. Morrison eds., 2013). These politicians include governors, state legislators, mayors, city councillors, and county commissioners. *Id.*

209 Bagenstos, *supra* note 190, at 9.

ing recessions, “the worst possible time, from a programmatic perspective, to cut aid to poor people.”²¹⁰

B. Benefits of “Federalism by Waiver”

Despite such consequences, the overall effect of an increase in waiver grants will likely be positive. First, with respect to “picket fence federalism,” the “benefits of [maintaining] elected generalists’ power, especially in the context of intergovernmental programs, are less self-evident than the benefits with respect to comprehensive planning and budgeting.”²¹¹ There is clear value in having individuals who are highly knowledgeable and educated with respect to a particular policy area making decisions. Further, the bureaucratic alliance can actually work to the advantage of political generalists. This is because “subject-matter experts in the federal bureaucracy, supporting their allies in state government, can work to overcome the resistance of generalist federal officials to state-level innovations.”²¹² Further, the lack of available alternatives to the federalism by waiver framework could easily defeat the statutory erosion argument.²¹³ If states are not given the option to apply for a waiver of federal spending conditions, a state may simply refuse compliance, as “[f]ederal agencies are unlikely to terminate funding for relatively minor violations of the rules governing a spending program.”²¹⁴ Alternatively, with more complex spending programs, such as Medicaid or the No Child Left Behind Act, states may decide to opt out of the program entirely.²¹⁵ A clear waiver system provides a mechanism for federal agencies to engage states before they depart from the strict requirements of funding statutes, to negotiate for provisions that preserve the key goals—as the administration sees it—of the statutes at issue, and to do so in a context that preserves a measure of public accountability.²¹⁶

Further, with the waiver process as a clear option, any disregard of governing rules will justify enforcement actions that might not be

210 *Id.*

211 Hills, *supra* note 201, at 1240.

212 Bagenstos, *supra* note 190, at 6.

213 *See id.* at 9.

214 *Id.* (noting that “third-party private enforcement of [governing] rules have been increasingly closed off by the Supreme Court’s restrictive private-right-of-action jurisprudence.”). *See also* Ruger, *supra* note 85, at 373 (explaining that “the federal circuit courts have held almost uniformly that Medicaid’s equal access provision and other statutory terms do not contain the sufficient rights-creating language to provide a foundation for private enforcement”).

215 Bagenstos, *supra* note 190, at 11.

216 *Id.* at 9.

triggered by the substance of a state's violation in and of itself.²¹⁷ With Medicaid, for example, CMS has published detailed criteria for assessing waiver requests to provide states with advanced notice.²¹⁸ Another advantage of providing readily accessible criteria is that state and federal officials can more easily be held accountable for their decisions.²¹⁹ For complex spending programs, a "waiver regime can provide a safety valve that preserves conditional spending programs at the same time that it relieves states of some of the obligations imposed by them."²²⁰ Thus, without waivers, statutory erosion would likely still occur and to a much greater degree as programs that benefit the less privileged are completely extinguished.

Finally, one of federalism by waiver's greatest benefits is that it provides a powerful tool to negotiate a balance between national standards and local variation "but with lower stakes . . . than a regime that imposes strict statutory standards on states and provokes them to challenge those standards on constitutional grounds."²²¹ Such "experimentation" can lead to more effective and efficient programs at both the national and state level.

CONCLUSION

While some states may ultimately decide to expand their Medicaid programs, many remain in staunch opposition and are unlikely to provide health insurance to their low-income citizens according to the terms of the ACA. For these states, negotiating a premium assistance model through a § 1115 waiver may be a viable option, as complete refusal to expand Medicaid or pursue an alternate program will mean the loss of substantial federal funding and will likely cause a net reduction in state budgets.

The premium assistance model's overall cost-effectiveness is presently unknown, since costs will be shaped in the short run and over the long term by factors such as "market rates in the exchanges—which may decrease with competition for new enrollees—as well as Medicaid's reimbursement rates—which may increase to convince

217 *Id.* at 10.

218 *See Home & Community-Based Services 1915(c)*, MEDICAID.GOV, <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/home-and-community-based-services-1915-c.html> (last visited Mar. 24, 2014).

219 *See Bagenstos*, *supra* note 190, at 10.

220 *Id.*

221 *Id.* at 12.

more providers to treat millions added to the program.”²²² Further, since the federal government will be “footing the bill” for expanded state Medicaid programs during the first three years, it is unclear whether an expansion through the exchanges will cost the states more over the long term. Any increase in costs associated with providing private insurance rather than expanding Medicaid is, however, very unlikely to cause more harm to state budgets than the complete loss of all federal funding associated with the refusal to participate in any form of “expansion.” Thus, not only will the ACA’s goal of providing health insurance to all United States citizens be thwarted, but taxpayers in states refusing both the ACA’s Medicaid expansion and an alternate “expansion” through a § 1115 waiver will likely suffer substantial adverse financial consequences in the long-term. Pursuing some form of an “expansion” will, therefore, benefit both states and the federal government by furthering the ACA’s objectives and generating funding states can use to provide health insurance coverage to low-income citizens while also improving state economies. Finally, although an increase in waiver applications has the potential to alter the structure of federalism as applied to joint federal and state programs, the overall effect of a rise in waiver activity is likely to be positive.

222 *Premium Assistance in Medicaid*, *supra* note 138.