

Can This Marriage Be Saved? Federalism and the Future of U.S. Health Policy Under the Affordable Care Act

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I. INTRODUCTION

In law, as in life, relationships are everything.

As with all transformational laws, the Patient Protection and Affordable Care Act,¹ hereinafter referred to by its popular name, the Affordable Care Act (ACA or the Act), derives its power from the extent to which it realigns prior relationships and from adding new rights and duties: Between individuals and government through the creation of a right to accessible, affordable health insurance and a concomitant “personal responsibility” to secure it;² between the insurance industry

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified as amended in scattered sections of 26 and 42 U.S.C.). The Obama Administration refers to these two laws jointly as The Affordable Care Act. *See, e.g.*, 78 Fed. Reg. 27,486 (May 10, 2013).

2. Patient Protection and Affordable Care Act sec. 1501, § 5000A, 124 Stat. at 244–50 (adding section 5000A to the Internal Revenue Code of 1986);

and the government through reforms aimed at assuring access to affordable coverage;³ between larger employers and workers through the Act's "shared responsibility" requirements;⁴ and between health care providers and public and private insurers through provisions aimed at long-term restructuring in how health care is organized and paid for.⁵

But it is fair to say that no relationship within the health care system is more affected by the Act than that between the federal government and state governments. Indeed, the ACA establishes a legal approach to national health reform that, at its core, rests on the shoulders of this relationship. First, the Act expands the pre-existing federal-state partnership in the regulation of health insurance while establishing a new Marketplace for affordable coverage.⁶ Second, the Act expands the joint federal-state investment in health care for the poor (this time, with the lion's share coming from the federal partner) through an expanded Medicaid program.⁷ As of May 2013, the Congressional Budget Office (CBO) has estimated that by 2022, twenty-five million Americans will gain coverage as a result of this recalibrated set of relationships.⁸

see §1401, 124 Stat. at 213–20 (establishing a legal entitlement on the part of qualified individuals to advanced premium tax credits by amending chapter 1 of the Internal Revenue Code of 1986); §1402, 124 Stat. at 220–24 (adding an entitlement to cost-sharing reduction assistance in the case of eligible individuals).

3. § 1001, 124 Stat. at 130–38 (amending the Public Health Service Act (PHSA)); § 1201, 124 Stat. at 154–61 (same); § 1562(e), 124 Stat. at 270 (amending the Employee Retirement Income Security Act of 1974 (ERISA) to apply certain PHSA insurance reforms to ERISA plans).

4. § 1513, 124 Stat. at 253–56 (amending chapter 43 of the Internal Revenue Code of 1986 to add a shared employer responsibility to contribute toward the cost of coverage in certain cases).

5. *See, e.g.*, § 3021, 124 Stat. at 389–95 (establishing the Center for Medicare and Medicaid Innovation); § 3022, 124 Stat. at 395–99 (establishing the Medicare Shared Savings Program); § 3023, 124 Stat. at 399–403 (establishing a national pilot program on payment bundling); § 3025, 124 Stat. at 408–13 (establishing a readmissions reduction program).

6. *See infra* Part II.

7. *See infra* Part III.

8. The CBO's original cost estimates associated with the Act put the total number of newly insured Americans at thirty-one million. Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to the Honorable Harry Reid, U.S. Senate Majority Leader, tbl.3 (Mar. 11, 2010), *available at* http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11307/reid_let_er_hr3590.pdf (estimating a reduction of thirty-one million uninsured nonelderly people by 2019). Following the United States Supreme Court's

Of course, to achieve the Act's intended effects, these legislative relationships actually need to become operational. But as of spring 2013, the political animus that pervaded the country, coupled with the near mortal blow dealt to the Act's structure by the United States Supreme Court's Medicaid ruling in *National Federation of Independent Business v. Sebelius* (*NFIB*),⁹ placed half of all states on track to refuse to either implement their own Health Insurance Marketplaces¹⁰ or adopt the Medicaid coverage expansions for poor adults.¹¹ Moreover, the vast majority of states had not yet taken steps to implement the far-reaching insurance reforms specified under the Act; indeed, as of the winter of 2013, only one state had done so.¹²

decision in *National Federation of Independent Business v. Sebelius*, 32 S. Ct. 2566 (2012), the CBO revised this figure down to about thirty million as a result of the Court's holding that states could opt out of the mandatory 2014 Medicaid adult expansion. CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 20 tbl.3 (2012) [hereinafter CBO ESTIMATES], available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>. In May 2013, the CBO further revised the figure down to twenty-five million by 2022 as a result of new estimates lowering the number of individuals with employer health insurance. CONG. BUDGET OFFICE, ESTIMATE OF THE EFFECTS OF THE AFFORDABLE CARE ACT ON HEALTH INSURANCE COVERAGE 1 tbl.1 (2013), available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf.

9. 132 S. Ct. 2566, 2601–09 (2012) (holding that the Medicaid expansion was optional, not mandatory, for states).

10. Health Insurance Marketplaces are also known as the American Health Benefit Exchanges under the ACA. See Patient Protection and Affordable Care Act § 1311, 124 Stat. at 173–81. In 2012, the Obama Administration introduced the term “Health Insurance Marketplace” in order to make the concept more understandable to the public, most of whom had absolutely no idea what an Exchange was. See, e.g., Press Release, President Barack Obama, Remarks by the President on Supreme Court Ruling on the Affordable Care Act (June 28, 2012), available at <http://www.whitehouse.gov/the-press-office/2012/06/28/remarks-president-supreme-court-ruling-affordable-care-act>.

11. See *supra* note 9.

12. KATIE KEITH ET AL., COMMONWEALTH FUND, IMPLEMENTING THE AFFORDABLE CARE ACT: STATE ACTION ON THE 2014 MARKET REFORMS 2 (2013), available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2013/1662_Keith_implementing_ACA_state_action_2014_reform_brief_v2.pdf (finding that only one state had implemented all seven 2014 market reforms as of October 2012).

The pressure on Republican state leaders to resist any sort of accommodation to the Act is intense,¹³ with unending polemics against cooperation delivered by its ideological opponents,¹⁴ as well as repeated, hammering blows against any move toward cooperative federalism administered by the Republican-controlled United States House of Representatives. By May 2013, the House had voted thirty-seven separate times to repeal the Act in its entirety.¹⁵ These intense and unrelenting attacks in turn appear to be having their intended effect, helping push over two dozen states by mid-2013 to act

13. See, e.g., Sandhya Somashekhar, *GOP Governors' Endorsements of Medicaid Expansion Deepen Rifts Within Party*, WASH. POST, June 3, 2013, http://articles.washingtonpost.com/2013-06-02/national/39697956_1_medicaid-expansion-medicaid-plan-gop-governors.

14. See, e.g., MICHAEL F. CANNON, CATO INST., 50 VETOES: HOW STATES CAN STOP THE OBAMA HEALTH CARE LAW (2013), available at http://object.cato.org/sites/cato.org/files/pubs/pdf/50-vetoes-white-paper_1.pdf. Perhaps the most thorough documentation of how the Act's opponents have turned its federalism structure into a potent weapon against itself can be found in *50 Vetoes*, which focuses on how states can stop the ACA from taking effect by refusing to expand Medicaid and by refusing to establish Health Insurance Marketplaces (the newest term for what are known as "exchanges" under the Act). *Id.* One might wonder why stopping states from establishing their own Marketplaces would undermine the Act, since as discussed later in this article, the law provides for default federal administration of the new Marketplace system in any state that elects not to operate its own. See *infra* notes 62–87 and accompanying text. The answer lies in a companion legal theory, now working its way through the courts, that the Act's terms prohibit federally facilitated Marketplaces (as they are known) from offering premium subsidies to low- and moderate-income families and individuals or collecting penalties on larger employers that do not offer coverage. Compare Timothy Jost, *Tax Credits in Federally Facilitated Exchanges Are Consistent with the Affordable Care Act's Language and History*, HEALTH AFF. BLOG (July 18, 2012, 7:27 PM), <http://healthaffairs.org/blog/2012/07/18/tax-credits-in-federally-facilitated-exchanges-are-consistent-with-the-affordable-care-acts-language-and-history/> (arguing that nothing in the Act bars subsidies and penalties in federally facilitated Marketplaces), with Michael Cannon & Jonathan Adler, *The Illegal IRS Rule to Expand Tax Credits Under the PPACA: A Response to Timothy Jost*, HEALTH AFF. BLOG (Aug. 1, 2012, 10:52 AM), <http://healthaffairs.org/blog/2012/08/01/the-illegal-irs-rule-to-expand-tax-credits-under-the-ppaca-a-response-to-timothy-jost/> (responding to Professor Jost's arguments).

15. Sarah Kliff, *Yes, the 37th Obamacare Repeal Vote Matters*, WASH. POST WONKBLOG (May 16, 2013, 10:55 AM), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/05/16/yes-the-37th-obamacare-repeal-vote-matters/> (arguing that each repeal vote has helped fuel uncertainty and further popular resistance to implementation).

against the social, political, economic, and moral interests of their own populations.¹⁶

For better or worse, cooperative federalism is the platform on which the Affordable Care Act rests. For this reason, mending the federalism relationship, or at least building a compensatory legislative structure to overcome its shortcomings if détente fails, has become vital. It is important to think about what such an alternative arrangement might look like even if, at the moment, it appears that prospects for any federal legislative intervention are dim at best.¹⁷ One can only hope.

In the spirit of hoping for a chance at further legislative reform if the marriage cannot be saved, I take a closer look at the two federalism relationships—one regulatory, the other investment—that lie at the heart of the Act. I surmise that even if sputtering and fragile, the regulatory partnership actually is built to weather current conditions and that ultimately, it will enable full implementation of the market reforms that the Act sets in motion.

I also conclude, however, that at least where coverage of poor adults and their families is concerned, the Medicaid relationship is sufficiently under water to necessitate a federal fallback system, comparable in spirit to the federal fallback that has been designed for the regulatory side of the ledger. Creating such a fallback is essential if the nation is to avert the terrible spectacle of allowing any individual state to exclude its poorest residents from coverage. Of course, we have been down this road before; it took states many years after Medicaid's 1965 enactment to implement the program fully. Indeed,

16. See, e.g., Elise Viebeck, *Perry Doubles Down Against ObamaCare's Medicaid Expansion*, THE HILL (Apr. 1, 2013, 6:10 PM), <http://thehill.com/blogs/healthwatch/medicaid/291257-perry-doubles-down-against-medicaid-expansion> (reporting on the Governor's April 2013 press conference announcing his opposition despite the enormous gains to Texas). At the press conference, a number of high-ranking federal officials joined him, most notably, Senator Ted Cruz, perhaps the most outspoken opponent of the Act in the United States Senate at the time of this writing and a leader of the Tea Party movement. *Id.* Viebeck, having talked with colleagues in Texas, noted that during the press conference, Governor Perry was absolutely flanked by prominent Republicans and looked as though he was being held-up. *Id.*

17. See Jonathan Weisman & Robert Pear, *Partisan Gridlock Thwarts Effort to Alter Health Law*, N.Y. TIMES, May 27, 2013, at A1.

Arizona did not implement Medicaid until 1982.¹⁸ One might argue that in the name of federalism the nation should continue to take this long view and nudge states into coming around through an array of incentives.

But I argue here that what may have been tolerable in Medicaid's early years—when the entire health insurance system was still evolving and our understanding of the role of health insurance in access to care was so much more limited—is no longer tolerable in 2013 when we stand on the precipice of seeing millions shut out of coverage under health reform. To allow one, a handful, or two dozen states to lock the poor out of coverage in the name of federalism is simply unthinkable, especially now that the nation has managed to build a viable, alternative mechanism for extending near-universal affordable coverage to the population. In 1965 there was no viable, alternative pathway to achieving affordable coverage for uninsured, low-income individuals. Now there is.

The Court's Medicaid ruling in *NFIB*¹⁹ can be thought of as having launched one of the most sobering federalism experiments the nation has yet undertaken. But we need to collectively call the social experiment to a halt now, just as researchers presumably would do in the case of any fundamentally unethical research design. One could argue that the decision allows the country to test the practical consequences of constitutional federalism, to determine whether large financial incentives (memorably described by Justice Kagan as “a boatload” of federal funds during the *NFIB* oral argument)²⁰ are sufficient to overcome regional,

18. Erick Eckholm, *Late Starter in Medicaid, Arizona Shows the Way*, N.Y. TIMES, Aug. 7, 1991, at A1.

19. See *supra* notes 9–12 and accompanying text.

20. For Justice Kagan's memorable characterization of the Act's Medicaid eligibility expansion funding levels during oral argument on March 28, 2012, see Transcript of Oral Argument at 4, *Florida et al. v. Dep't. of Health & Human Servs.*, 132 S. Ct. 2566 (2012) (No. 11-400), available at http://www.supremecourt.gov/oral_arguments/argument_transcripts/11-400.pdf. Clearly, this was not enough for her to vote with the dissent on this issue. Indeed, Medicaid's sheer size, and the states' high dependence on the program, became a crucial aspect of the majority opinion finding that the 2014 adult expansion constituted an unconstitutional coercion. See Samuel R. Bagenstos, *The Anti-Leveraging Principle and the Spending Clause After NFIB*, 101 GEO. L.J. 861, 873–76, 906, 912–16 (2013) (discussing the conditions under which a federal law conceivably could result in unconstitutional coercion, including the size of federal funding involved,

philosophical, and cultural differences about the federal-state relationship. But this is not a question that is worthy of answer in a just society. It is too late in our ethical evolution even to ask questions such as the one that effectively has been posed in the wake of the decision. The notion of testing the full consequences of constitutional federalism pales when compared to the broader public interest in promoting population health and social justice. The states that, as of mid-2013, are on the road to excluding the poor account for more than half of all uninsured people in the United States.²¹

II. THE ACT'S DELICATE FEDERAL-STATE REGULATORY PARTNERSHIP

In many respects, the basic approach to the regulation of health insurance in the United States remains undisturbed under the Act. Indeed, the Act builds on a pre-existing federalism framework. It is true that where ERISA-governed health plans are concerned,²² federal law continues to displace state insurance regulation in the case of self-insured plans and to completely preempt state law remedies generally, regardless of the insured status of ERISA health benefit plans.²³

At the same time, the ACA preserves the partnering structure codified under the McCarran-Ferguson Act,²⁴ while considerably ramping-up the level of federal intervention into the business of insurance regulation.²⁵ This ramped-up

changing the terms of cooperating in an “entrenched” federal program, and attempting to tie separate programs into a package deal).

21. Robert Pear, *States' Policies on Health Care Exclude Poorest*, N.Y. TIMES, May 25, 2013, at A1.

22. The Employee Retirement Income Security Act of 1974 (ERISA) governs health plans sponsored by private employers other than churches. 29 U.S.C. § 1002 (2012).

23. See *Aetna Health Inc. v. Davila*, 542 U.S. 200, 221 (2004); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47–57 (1987); *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739–40 (1985). For a discussion of ERISA, preemption of state insurance and other laws, and the ACA, see SARA ROSENBAUM ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM chs. 8, 21 (2d ed. 2012).

24. 15 U.S.C. §§ 1011–1015 (2012) (declaring that states have power to regulate and tax the “business of insurance” where Congress has been silent).

25. See Sara Rosenbaum, *Realigning the Social Order: The Patient Protection and Affordable Care Act and the U.S. Health Insurance System*, 7 J. HEALTH & BIOMEDICAL L. 1, 28 (2011) (“The Affordable Care Act changes these federal-state dynamics to a considerable degree. In the private health insurance market, the federal presence is much more heavily felt. Although

intervention is, of course, what is set to pack such an insurance market punch beginning in 2014.²⁶ The Act accomplishes its objectives by amending a series of pre-existing—and relatively limited—federal regulatory standards added to the Public Health Service Act in 1996 by the Health Insurance Portability and Accountability Act (HIPAA).²⁷ Furthermore, in recognition of the imperviousness of self-insured plans to state insurance laws, the ACA carries many of its Public Health Service Act provisions over to ERISA itself,²⁸ thereby ensuring their application to both fully-insured and self-insured ERISA plans.

Yet even as the ACA introduces powerful structural reforms into the legal fabric of insurance regulation, it also retains HIPAA's previous deferential approach to shared enforcement responsibilities.²⁹ As has been the case with the Congressional approach to insurance regulation since the enactment of McCarran-Ferguson,³⁰ the ACA, like its HIPAA predecessor, adopts a highly interstitial approach to the

states maintain their primary regulatory function and can maintain both Exchange and non-Exchange markets, the Act fundamentally alters the federal-state relationship by creating a federal framework for the regulation of health insurance.”).

26. See Sara Rosenbaum, *The Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice*, 126 PUB. HEALTH REP. 130, 130 (2011) (“Full implementation occurs on January 1, 2014, when the individual and employer responsibility provisions take effect, state health insurance Exchanges begin to operate, the Medicaid expansions take effect, and the individual and small-employer group subsidies begin to flow.”).

27. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (amending the Public Health Service Act). See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (amending the Public Health Service Act).

28. Patient Protection and Affordable Care Act § 1562(e), 124 Stat. at 270.

29. See Health Insurance Portability and Accountability Act sec. 102, § 2722, 110 Stat. at 1968 (“[E]ach State may require that health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State in the small or large group markets meet the requirement of this part with respect to such issuers.”).

30. McCarran-Ferguson Act, 15 U.S.C. §§ 1011–1015 (2012); see Stephanie Kanwit, *The Purchase of Insurance Across State Lines in the Individual Market*, 37 J.L. MED. & ETHICS 152, 154 (2009) (“The Act had two aims: (1) to re-affirm the role of the states as the primary regulators of the insurance industry while preserving federal authority to regulate insurance through “specific” enactments; and (2) to provide limited federal antitrust immunity for the insurance industry.”).

exercise of federal powers and maintains states in the leadership position.³¹

Even a brief recitation of the key ACA reforms makes clear that the Act's substantive intervention into health insurance regulation—the quid pro quo for the law's personal responsibility requirement and its attendant penalties³²—is so sweeping as to fundamentally alter the character of state-regulated health insurance products. This is especially true in the case of products sold in the individual and small-group markets, whether inside or outside the new Health Insurance Marketplaces.³³ The most salient reforms tend to involve access to coverage, but the law also contains important modifications of coverage design, particularly where individual and small-group products are concerned.³⁴ The general reforms applicable to all markets—large, small, fully-insured, and self-insured—are as follows: a prohibition of discriminatory health insurance rates other than those permissible under a modified community rating system;³⁵ guaranteed issuance of coverage³⁶ and renewal of policies;³⁷ a ban against discrimination on the basis of health

31. See Rosenbaum, *supra* note 25, at 27–28 (“To be sure, ERISA, and to a much lesser extent HIPAA, represented major departures from the principles embodied in the McCarran Ferguson Act . . . The Affordable Care Act changes these federal-state dynamics to a considerable degree. In the private health insurance market, the federal presence is much more heavily felt.”). But see Christopher B. Serak, *State Challenges to the Patient Protection and Affordable Care Act: The Case for A New Federalist Jurisprudence*, 9 IND. HEALTH L. REV. 311, 317 (2012) (“The Patient Protection and Affordable Care Act, while perhaps within the judicial exception to McCarran-Ferguson, will eliminate the states’ monopoly over intrastate health insurance transactions and severely limit the areas of insurance regulation over which the states could still possibly enjoy the protections of McCarran-Ferguson. In effect, the Patient Protection and Affordable Care Act represents a near-total shift in the locus of insurance regulation from the states to the federal government.”).

32. Patient Protection and Affordable Care Act § 1501, 124 Stat. at 242–50.

33. See, e.g., *infra* notes 52–55 and accompanying text.

34. Compare *infra* notes 35–51 and accompanying text, with *infra* notes 52–55 and accompanying text.

35. Patient Protection and Affordable Care Act sec. 1201, § 2701, 124 Stat. at 155 (amending Public Health Service Act, Pub. L. No. 78-410, 58 Stat. 682 (1944)). Section 1201 prohibits discrimination based on status as individual versus family, geographic area, age, and tobacco use.

36. Sec. 1201, § 2702, 124 Stat. at 156.

37. Sec. 1201, § 2703, 124 Stat. at 156.

status;³⁸ a prohibition on excessive waiting periods;³⁹ coverage of routine health costs associated with participation in approved clinical trials;⁴⁰ a ban on annual and lifetime coverage limits for most covered services;⁴¹ a prohibition on rescissions of coverage except in cases of fraud;⁴² coverage of certain recommended preventive health services;⁴³ a prohibition against the use of preexisting condition exclusions;⁴⁴ an extension of dependent coverage, when offered, to age twenty-six;⁴⁵ the use of uniform explanation of coverage documents and standardized definitions;⁴⁶ provision of certain information to the Department of Health and Human Services (HHS) Secretary;⁴⁷ the use of quality rating systems;⁴⁸ establishment of minimum medical-loss ratios and reporting requirements for the cost of coverage;⁴⁹ an expanded appeals process including access to external appeals;⁵⁰ and certain patient protections related to emergency care, choice of health care professional, and access to pediatric care.⁵¹

In the case of the individual and small-group market, the Act goes a major step further by establishing specified coverage parameters known as “essential health benefits.”⁵² These “essential health benefits” consist of ten specified coverage categories, along with specified cost-sharing and actuarial

38. § 2705, 124 Stat. at 156–60. An exception is carved-out for wellness programs. *Id.* at 157.

39. Waiting periods exceeding ninety days are prohibited. *Id.* § 2708, 124 Stat. at 161.

40. Sec. 10103, § 2709, 124 Stat. at 892.

41. Sec. 1001, § 2711, 124 Stat. at 131.

42. Sec. 1001, § 2712, 124 Stat. at 131.

43. § 2713, 124 Stat. at 131–32.

44. Sec. 1201, § 2704, 124 Stat. at 154–55.

45. Sec. 1001, § 2714, 124 Stat. at 132.

46. § 2715, 124 Stat. at 132–35.

47. Sec. 10101, § 2715A, 124 Stat. at 844.

48. Sec. 1001, § 2717, 124 Stat. at 135–36. In a memorable qualifier, Congress specified that the national quality rating system to be developed must ensure “Protection of Second Amendment Gun Rights” in wellness and prevention programs by limiting data collection to exclude information on lawful gun ownership or use. Sec. 10101, § 2716(c), 124 Stat. at 884–85.

49. Sec. 10101, § 2718, 124 Stat. at 885–87.

50. Sec. 1001, § 2719, 124 Stat. at 137–38.

51. Sec. 10101, § 2719A, 124 Stat. at 888–91.

52. § 1302, 124 Stat. at 163–68.

value rules.⁵³ Furthermore, the essential health benefit statute contains an unprecedented statutory ban against discrimination in the content of coverage on the basis of disability⁵⁴—a breakthrough in the regulation of health insurance in the United States, although implemented timidly thus far by the Obama Administration.⁵⁵

These regulatory reforms are accompanied by the establishment of a special Health Insurance Marketplace, which combines the equivalent of an online shopping system for certain subsets of the overall health insurance market (i.e., individual and small group plans)⁵⁶ with a special regulatory environment for overseeing the sale of federally-subsidized insurance plans to this part of the market through a system of advanced premium tax credits for individuals and tax credits for small, low-wage employers.⁵⁷ At their option, states may operate their own Marketplace under broad federal direction (known as state-based Marketplaces⁵⁸) or elect to have the

53. *Id.* (“[S]uch benefits shall include at least the following general categories . . . : (A) Ambulatory patient services. (B) Emergency services. (C) Hospitalization. (D) Maternity and newborn care. (E) Mental health and substance use disorder services, including behavioral health treatment. (F) Prescription drugs. (G) Rehabilitative and habilitative services and devices. (H) Laboratory services. (I) Preventive and wellness services and chronic disease management. (J) Pediatric services, including oral and vision care.”).

54. § 1302(b)(4)(B), 124 Stat. at 163–68.

55. Despite the non-discrimination provision, the Obama Administration’s final regulations governing essential health benefits virtually failed to do more than simply repeat the language of the statute. For a discussion of the weaknesses of the Administration’s implementation efforts in the area of non-discrimination in coverage, see Sara Rosenbaum & Joel Teitelbaum, *A Lost Opportunity for Persons with Disabilities? The Final Essential Health Benefit Rule*, HEALTH AFF. BLOG (Mar. 11, 2013, 10:20 AM), <http://healthaffairs.org/blog/2013/03/11/a-lost-opportunity-for-persons-with-disabilities-the-final-essential-health-benefits-rule/>.

56. See, e.g., *What is the Health Insurance Marketplace?*, HEALTHCARE.GOV, <https://www.healthcare.gov/what-is-the-health-insurance-marketplace> (last visited Sept. 19, 2013) (providing a lay description of the Marketplace).

57. The tax credit system is set forth at sections 1401 (individuals) and 1421 (small businesses) of the Affordable Care Act.

58. See *State Health Insurance Marketplaces*, CENTERS FOR MEDICARE & MEDICAID SERVICES, <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/state-marketplaces.html> (last updated Oct. 1, 2013) (“States across the country have received grants to establish a new marketplace. States can create and operate their own marketplace (State-based Marketplace) or a hybrid called a State Partnership Marketplace in which the state runs certain functions. A Partnership Marketplace allows states to make key decisions and

federal government operate a “federally-facilitated” Marketplace either with or without a “State Partnership.”⁵⁹

This conceptual approach to insurance reform—preserving state primacy over health insurance regulation while introducing transformational federal standards designed to fundamentally remake the market at its core⁶⁰—raises two inevitable questions. First, how, exactly, do these transformational reforms become integrated into state regulatory enforcement machinery, since as noted, state primacy is preserved? Second, what if state primacy fails either because the state lacks the resources to carry out aggressive insurance regulation or elects not to do so? Basic matters of constitutional federalism simmer just below the surface of these questions. In order to toe the constitutional line and avoid a result that might be labeled commandeering,⁶¹

tailor the marketplace to local needs and market conditions. The Federal government will establish and operate a marketplace in those states that do not establish their own.”).

59. See Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,325 (Mar. 27, 2012) (codified at 45 C.F.R. pts. 155, 156, and 157) (“In the Exchange establishment proposed rule, [the HHS] introduced the concept of a Partnership model in which HHS and States work together on the operation of an Exchange A Partnership Exchange would be a variation of a Federally-facilitated Exchange. Section 1321(c) of the Affordable Care Act establishes that if a State does not have an approved Exchange, then HHS must establish an Exchange in that State; the statute does not authorize divided authority or responsibility. This means that HHS would have ultimate responsibility for and authority over the Partnership Exchange. In a Partnership Exchange, we intend to provide opportunities for a State to help operate the plan management function, some consumer assistance functions, or both.”); see also 45 C.F.R. §§ 155.100–1328 (2012) (explaining state options in establishing and managing exchanges).

60. See Rosenbaum, *supra* note 25, at 7–8 (“It is the states that regulate the individual and group health insurance markets, and it is the states that will be called upon to assure application of federal reforms to insured plans, even as the federal government maintains primacy over the self-insured market. It is the states that will bear primary responsibility for making Exchanges work for individuals and small employers and for guaranteeing that adverse selection against Exchanges does not undermine the ability to grow insurance products that meet the needs of workers and their families without access to employer coverage.”).

61. See, e.g., *Printz v. United States*, 521 U.S. 898, 925–33 (1997); see also Matthew D. Adler, *The Supreme Court’s Federalism: Real or Imagined? State Sovereignty and the Anti-Commandeering Cases*, 574 ANNALS AM. ACAD. POL. & SOC. SCI. 158, 158 (2001) (“The anti-commandeering doctrine, recently announced by the Supreme Court in *New York v. United States* and *Printz v. United States*, prohibits the federal government from commandeering state

Congress has developed an enforcement approach under which the federal government is allowed to tread—but delicately—in the face of state nonenforcement.⁶² The solution may be messy, but conceptually it hangs together. To be sure, it probably will be sorely tested under the Act's far more aggressive federal standards, but for the time being, the approach is at least conceptually workable.

The ACA's enforcement system preserves the 1996 HIPAA approach, as codified in the Public Health Service Act,⁶³ although regulations issued in 2012 take a slightly more ambitious approach to articulating what could trigger the use of federal fallback enforcement powers.⁶⁴ Under the Public Health Service Act approach, states remain the principal enforcers, but the federal government positions itself to act if all else fails. States have the option, in both the individual and group markets, to decide whether they will take the enforcement lead or defer to federal authority.⁶⁵ Should a state deliberately elect *not* to enforce the law, the HHS Secretary is

governments: more specifically, from imposing targeted, affirmative, coercive duties upon state legislators or executive officials. This doctrine is best understood as an external constraint upon congressional power—analogous to the constraints set forth in the Bill of Rights—but one that lacks an explicit textual basis.”)

62. See *infra* text accompanying notes 63–87.

63. See, e.g., HEALTH POLICY ALTS., INC., SUMMARY OF PATIENT PROTECTION AND AFFORDABLE CARE ACT 34 (2010), available at <http://acscan.org/pdf/healthcare/implementation/PPACA-HPA-summary.pdf> (“If a state fails to establish an Exchange within 24 months of enactment . . . the Secretary is required . . . to establish and operate an Exchange within the state and to take actions to implement the other federal requirements. Enforces federal authority related to non-electing states through the HIPAA enforcement provisions of the PHS Act (newly designated § 2736(b)) without regard to any limitation on the application of those provisions to group health plans.”).

64. See 45 C.F.R. §§ 155.101–.1328 (2012); see also § 155.105(f) (“If a State is not an electing State under § 155.100(a) or an electing State does not have an approved or conditionally approved Exchange by January 1, 2013, HHS must (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State.”).

65. 42 U.S.C. § 300gg–22(a)(1) (Supp. V 2011) (“[E]ach State may require that health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State in the individual or group market meet the requirements of this part with respect to such issuers.”); Public Health Service Act, Pub. L. No. 78-410, § 2723(a)(1), 58 Stat. 682 (1944), amended by Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). Special rules apply to the enforcement of federal laws to nonfederal governmental health plans. See Public Health Service Act § 2724; 45 C.F.R. § 146.180 (2012).

empowered to step in.⁶⁶ Furthermore, the law enables the HHS Secretary to intervene following a “determination . . . that a state has failed to substantially enforce a provision” of federal law related to “the issuance, sale, renewal, and offering of health insurance coverage in connection with group health plans or individual health insurance.”⁶⁷ In other words, the Secretary can intervene in one of two situations. In the first, the state empowers intervention by informing her of its decision not to enforce the law. In the second, she empowers her own intervention by “determining” its necessity. This mutuality of empowerment represents a complicated but conceptually brilliant resolution to the constitutional problem of federalism. Equality and deference are maintained. Yet the law also allows for careful intervention.

Just how carefully the intervention has to proceed becomes clearer the more the regulations are scrutinized. As noted, the regulations provide for federal action in situations in which “a State notifies [the federal government] that it has not enacted legislation to enforce or that it is not otherwise enforcing” federal market requirements.⁶⁸ But the post-ACA regulations enable federal intervention under certain triggering circumstances, which range from the existence of a complaint filed with the Centers for Medicare and Medicaid Services (CMS),⁶⁹ which has jurisdiction over the health insurance market reforms,⁷⁰ to news media reports⁷¹ and “any other information” that suggests nonenforcement.⁷² Notably, the rule, like the statute, contemplates no independent and affirmative federal oversight system; that is, the federal government expects to sit passively until some third party brings

66. 42 U.S.C. § 300gg-22(a)(2); Public Health Service Act § 2723(a)(2).

67. 42 U.S.C. § 300gg-22(a)(2); Public Health Service Act § 2723(a)(2). The Public Health Service Act also lays out the Secretary’s enforcement authority as well as a federal enforcement process, which involves the imposition of civil money penalties, as well as an extensive process of review for determining liability. *Id.* § 2723(b). The authority to act on the issuer’s license remains solely a matter for a state. *Cf.* GARY CLAXTON, KAISER FAMILY FOUND., HOW PRIVATE HEALTH INSURANCE WORKS: A PRIMER 7–8 (2002), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/how-private-insurance-works-a-primer-report.pdf>.

68. 45 C.F.R. § 150.203(a) (2012).

69. *Id.* § 150.205(a).

70. *See id.* § 150.101.

71. § 150.205(c).

72. § 150.205(f).

nonenforcement to its attention.⁷³ But at the point at which evidence is received, the intervention machinery can begin to work.

The process spelled out in the rule, even as revised post-ACA, remains almost painfully deferential to state powers. Not only does the rule commit the federal government to wait for third-party news of enforcement failure, but furthermore, the federal intervention process begins with an assessment of “whether the affected individual or entity has made reasonable efforts to exhaust available State remedies.”⁷⁴ In other words, even when evidence of nonenforcement surfaces, the regulations throw the matter back into the very state system whose alleged failure is the subject of the third-party evidence.

Following this effort to accommodate a nonenforcing state, the regulations spell out a lengthy consultative process as part of complaint resolution,⁷⁵ with an eye toward nudging a state into action rather than immediately launching federal-enforcement activities (which involve a lengthy investigation and review process, followed by the imposition of civil money penalties in cases in which liability is established⁷⁶).⁷⁷ The delicate nature of the federal intervention underscores the degree to which the federal government has sought to create an environment in which CMS will step in only in the most sustained and egregious situations—only after it determines that a total breakdown in state enforcement truly has occurred. And even then, it does so with an eye toward ultimately negotiating a resolution that brings enforcement squarely back under state control.

In keeping with this tentative and circumspect approach to federal enforcement, CMS has gone to remarkable lengths to hide even this carefully circumscribed machinery from public view. Unlike the federal privacy rule, where HHS has taken a

73. See generally *id.* §§ 150.203–.205.

74. *Id.* §150.209.

75. The process involves notice to multiple state officials, thirty days for an initial response by the state with the option to extend the response time, a preliminary determination with more time granted to the state to show substantial enforcement, and ultimately a final determination regarding CMS’s intention to intervene in the enforcement process. *Id.* §§ 150.211–.221.

76. *Id.* §§ 150.301–.347.

77. 42 U.S.C. § 300gg–22 (Supp. V 2011); Public Health Service Act, Pub. L. No. 78-410, § 2723, 58 Stat. 682 (1944), amended by Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

relatively aggressive approach to publicizing its efforts to be the leader in privacy protection,⁷⁸ the tradition of insurance regulation is tilted so strongly in the direction of the states⁷⁹ that it is essentially impossible to find the entry point into the federal default system. If one peruses the website of the Center for Consumer Information and Insurance Oversight (CCIIO),⁸⁰ the insurance regulation arm of CMS, the site offers virtually no information on how to file a complaint or bring potential nonenforcement violations to federal attention. Instead, the CCIIO website offers a lengthy explanation—simultaneously legally meaningless and politically significant—about CCIIO’s partnership with the states.⁸¹ The site does notify the public about states that have formally notified CCIIO that they do not intend to enforce the market reforms.⁸² But even in this extreme situation, the agency does little to explain what the federal government will do other than notify issuers that policy forms must be sent to CMS for inspection and review. If a form is found to depart from federal standards, “CMS will notify issuers of any concerns . . . and will also conduct targeted market conduct examinations, as necessary, and respond to consumer inquiries and complaints”⁸³ If problems are uncovered, CMS notes that it will “work cooperatively” with the

78. See *Summary of the HIPAA Privacy Rule, Enforcement and Penalties for Noncompliance*, U.S. DEP’T HEALTH & HUMAN SERVICES, <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html> (last visited Sept. 20, 2013).

79. See Jana K. Strain & Eleanor D. Kinney, *The Road Paved with Good Intentions: Problems and Potential for Employer-Sponsored Health Insurance Under ERISA*, 31 LOY. U. CHI. L.J. 29, 32–37 (1999).

80. Ctr. for Consumer Info. & Ins. Oversight, *Compliance*, CENTERS FOR MEDICARE & MEDICAID SERVICES, <http://www.cms.gov/ccio/programs-and-initiatives/health-insurance-market-reforms/compliance.html> (last visited Sept. 9, 2013) [hereinafter *Compliance*].

81. *Id.* (“States and CMS have worked closely to ensure compliance with the health insurance accountability and consumer protections in federal law. The vast majority of states are enforcing the Affordable Care Act health insurance market reforms. Some states lack the authority, the ability to enforce these provisions, or both. CMS has responsibility for enforcing these requirements in a state that is not enforcing the health insurance market reforms either through a collaborative arrangement with the state or by direct enforcement to ensure all residents of the state receive the protections of the Affordable Care Act.”).

82. As of the end of March 2013, six states had done so: Arizona, Alabama, Missouri, Oklahoma, Texas, and Wyoming. *Id.*

83. *Id.*

state (the same state that notified CMS that it would not enforce the law) to “ensure compliance.”⁸⁴ CMS does not explain how compliance will be ensured in a situation in which a state, already having indicated that it will not enforce its licensure laws in relation to federal standards, will somehow be galvanized into action. Despite all of these limitations, it is clear that should push come to shove, the federal government is prepared to enforce the law if states fail to do so. As tentative as the process might be, the fallback system erases any doubt that the market reforms are nationwide in scope and leaves no room for a state to opt-out of the reforms themselves, even if it elects not to enforce the law or utterly fails to do so.⁸⁵ The presence of the federal fallback process also undoubtedly plays at least some role in keeping the number of nonenforcing states to a relative minimum. With the exception of the new Health Insurance Marketplaces, where there may be many good reasons to bring in the feds,⁸⁶ most states place a high value on their primacy in regulation of the insurance market.⁸⁷ The HIPAA federal fallback remedy, updated for the post-ACA legal environment, creates a framework of national assurance.

84. *Id.*

85. *See supra* notes 75–77 and accompanying text.

86. A number of states undoubtedly have opted not to run their own Marketplaces, at least in the initial implementation period, not because they intend to sink the law, but because setting up the new online system is so complex that they would prefer to have the federal government run it, at least early on. *Cf. Tracking the Progress of the Health Exchanges*, N.Y. TIMES, <http://www.nytimes.com/interactive/2013/10/04/us/opening-week-of-health-exchanges.html?ref=health> (last updated Oct. 26, 2013) (“Many of the Affordable Care Act’s health exchanges have struggled with technological problems since they opened on Oct. 1, though a few state-run exchanges have fared better than others.”). I would assume that ten years from now, states either will be running their Marketplaces or will be full partners with the federal government.

87. *Cf. Rosenbaum, supra* note 25, at 27 (“Congress enacted the McCarran Ferguson Act to clarify the states’ primacy where regulation of insurance is concerned. To be sure, ERISA, and to a much lesser extent HIPAA, represented major departures from the principles embodied in the McCarran Ferguson Act. ERISA shields all health plans from major bodies of state law. At the same time, states retain enormous discretion over the design and performance of health insurance products sold in the individual and group health markets.” (footnotes omitted)).

III. THE ENDANGERED FEDERAL-STATE MEDICAID RELATIONSHIP

At enactment, the ACA's Medicaid provisions were on track to add coverage by 2019 for an additional sixteen million⁸⁸ people beyond the sixty-five million already enrolled in the program at the time of passage.⁸⁹ Three years later, the CBO had officially scaled back expectations to thirteen million newly enrolled persons by 2023, a loss of some three million persons.⁹⁰ Even with these declining numbers, however, coverage for millions of poor citizens hangs in the balance,⁹¹ as the Court's Medicaid ruling in *NFIB* has imperiled the future of one of the principal legs of the four-legged stool—Medicaid, Medicare, employer-sponsored coverage, and the revamped individual insurance market—on which the post-reform coverage system rests.

88. Leighton Ku, *Explaining Recent Changes in CBO Projections of Health Insurance Coverage and Costs Under the Affordable Care Act*, HEALTHREFORMGPS (June 5, 2013), <http://healthreformgps.org/resources/explaining-recent-changes-in-cbo-projections-of-health-insurance-coverage-and-costs-under-the-affordable-care-act/>.

89. MACSTATS: MEDICAID AND CHIP PROGRAM STATISTICS, MEDICAID & CHIP PAYMENT & ACCESS COMMISSION 6 tbl.2 (2013), <https://docs.google.com/viewer?a=v&pid=sites&srcid=bWFjcGFjLmdvdnxtYWNwYWN8Z3g6NGQ5NDI1NTliNTkwNzgzNg> (showing Medicaid enrollment of over sixty-five million in fiscal year 2010).

90. Jessica Banthin & Sarah Masi, *CBO's Estimate of the Net Budgetary Impact of the Affordable Care Act's Health Insurance Coverage Provisions Has Not Changed Much Over Time*, CONG. BUDGET OFF. (May 14, 2013), <http://www.cbo.gov/publication/44176>. The reasons for this scaled back impact assessment are multiple and go beyond the legal free-fall created by the Court's Medicaid decision. For a clear explanation of the factors that have caused the budgeting arm of Congress to change its estimates over time, see Ku, *supra* note 88.

91. Recently-arrived legal U.S. residents who are not yet eligible for Medicaid (which imposes a five-year waiting period for adults and an optional waiting period for children) can go immediately into the Marketplace, even if their family incomes are well below its 100% subsidy threshold. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1401(a), 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (amending IRC to include § 36B(c)(1)(B)). Thus, states that refuse to expand Medicaid punish only U.S. citizens and long-term legal residents. As with the other arguments outlined below, the argument of equity for U.S. citizens has fallen generally on deaf ears in the resister states, but was highly persuasive in the case of the Governors of Arizona and New Mexico, both of which have very large immigrant populations.

The 2014 adult-expansion group began, of course, as a mandatory coverage group.⁹² Technically speaking, the group remains mandatory, since in the majority opinion, the Chief Justice was clear that nothing in its holding touched the underlying terms of the expansion, but instead was limited to the Secretary's power to enforce those terms against states' existing Medicaid programs.⁹³ What is left is a coverage group that remains technically mandatory but from which states can opt out without fear of federal reprisal (other than the loss of the funding that would have come with the expansion).⁹⁴ But rather than easing tensions, the decision has only made a bad federal-state Medicaid relationship worse,⁹⁵ transforming defeat of the expansion into a clarion call for opponents of the law.

Figure 1, which depicts state decisions related to the Medicaid expansion and implementation of state Exchanges, shows the state of affairs as of November 2013.⁹⁶ The twenty-four states that had rejected the expansion as of this date could fairly be characterized as the usual suspects: "red states" that

92. Patient Protection and Affordable Care Act § 2001, *amending* Social Security Act § 1902(a)(10)(A)(i).

93. Nat'l Fed'n of Indep. Bus. v. Sebelius (*NFIB*), 132 S. Ct. 2566, 2607 (2012) ("Nothing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that States accepting such funds comply with the conditions on their use. What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding."). For a full discussion of the decision, see Bagenstos, *supra* note 20; Nicole Huberfeld et al., *Plunging into Endless Difficulties: Medicaid and Coercion in National Federation of Independent Business v. Sebelius*, 93 B.U. L. REV. 1 (2013); Sara Rosenbaum & Timothy M. Westmoreland, *The Supreme Court's Surprising Decision on the Medicaid Expansion: How Will the Federal Government and States Proceed?*, 31 HEALTH AFF. 1663 (2012).

94. *See NFIB*, 132 S. Ct. at 2607 ("What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding. Section 1396c gives the Secretary of Health and Human Services the authority to do just that . . . [T]he Secretary cannot apply § 1396c to withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion.").

95. Lest people think that the Medicaid battle that engulfed the ACA is some sort of anomaly, they need only read ROBERT STEVENS & ROSEMARY STEVENS, *WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID* (1974), or the more recent account of Medicaid's tumultuous history in DAVID G. SMITH & JUDITH D. MOORE, *MEDICAID POLITICS AND POLICY: 1965-2007* (2008). The fight is always the same: money, state autonomy, and federal power.

96. *See infra* note 103.

served as the plaintiffs in the original Medicaid challenge to the Act⁹⁷ and whose political leaders (most,⁹⁸ not necessarily all) remain fully committed to total disruption of the law. Not only are these states home to the majority of uninsured people in the United States,⁹⁹ but they also tend to be the states whose populations are the most heavily disadvantaged in terms of poverty and health status in the country.¹⁰⁰ As the figure shows, the rejecter states tend to be located in the Deep South (or contiguous with it) and are home to enormous concentrations of low income (and disproportionately minority) residents who suffer the worst population health profiles in the nation,¹⁰¹ including health conditions considered highly amenable to proper medical care.¹⁰²

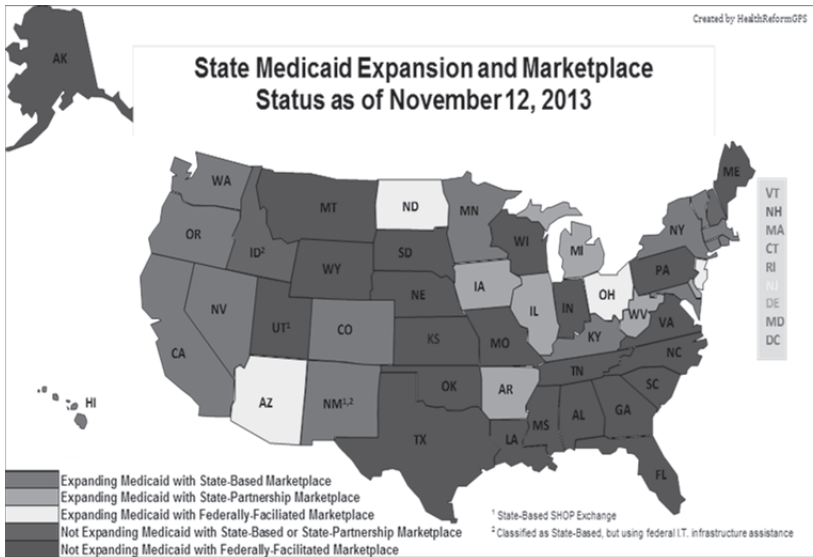
97. See *States' Positions in the Affordable Care Act Case at the Supreme Court*, KAISER FAM. FOUND., <http://kff.org/health-reform/state-indicator/state-positions-on-aca-case/> (last visited Oct. 22, 2013) (“On March 23, 2010, the state of Florida filed a lawsuit in federal district court challenging the constitutionality of the individual mandate and the Medicaid expansion included in the Affordable Care Act. Florida was joined by 25 other states . . .”).

98. For example, after leading the charge against the Medicaid expansion, Governor Rick Scott of Florida championed its adoption. He was bested by his Republican legislature, which ignored his pleas and those of scores of employer, health care, civic, and other organizations. See Sarah Kliff, *Florida Rejects Medicaid Expansion, Leaves 1 Million Uninsured*, WASH. POST WONKBLOG (May 5, 2013), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/05/05/florida-rejects-medicaid-expansion-leaves-1-3-million-uninsured/> (“Scott wouldn’t be the one to ‘deny Floridians’ a part of the health care law—but the Florida legislature had other plans.”); see also Pear, *supra* note 21 (“Several Republican governors, like Rick Scott in Florida, wanted to expand Medicaid, but met resistance from state legislators.”).

99. Pear, *supra* note 21 (“More than half of all people without health insurance live in states that are not planning to expand Medicaid.”).

100. See *infra* notes 101–02 and accompanying text.

101. See, e.g., Ctrs. for Disease Control & Prevention, *CDC Health Disparities and Inequality Report—United States, 2011*, 60 MORBIDITY & MORTALITY WKLY. REP. 1, 7 fig.4 (Supp. Jan. 14, 2011), available at <http://www.cdc.gov/mmwr/pdf/other/su6001.pdf> (showing the “Gini Index” of inequality in number of healthy days and average number of healthy days, by state). Deep South states that have announced their rejection of the Medicaid expansion or are leaning in that direction account for five of the bottom ten ranked states. Other states leaning toward rejection of Medicaid expansion, shown in Figure 1, make up most of the other bottom ten Gini states, with the exception of Kentucky and West Virginia. Health problems in the South are so serious that the region is identified in its entirety as a key focus of needed progress. AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP’T OF HEALTH & HUMAN SERVS., NATIONAL HEALTHCARE DISPARITIES REPORT 2011,

Figure 1¹⁰³

For fifty years, as fraught as the federal-state Medicaid relationship has been, it has somehow hung together. Indeed, during periods of threat, such as proposals to block grant Medicaid, states of all political stripes have tended to band together with Medicaid's federal supporters in order to stave-off the imposition of arbitrary aggregate limits on federal Medicaid

at 2 (2012), available at <http://www.ahrq.gov/research/findings/nhqrdr/nhdr11/nhdr11.pdf>.

102. See Ctrs. for Disease Control & Prevention, *supra* note 101, at 1; see, e.g., Medicaid Program: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, 77 Fed. Reg. 286 (Jan. 4, 2012). Pursuant to the Affordable Care Act, the United States Department of Health and Human Services has identified a "core set" of adult clinical quality measures that emphasize treatments and interventions that can appropriately manage serious and chronic health conditions in adults.

103. This map was created using a template found at *Re: USA Interactive Map Application*, ANDYPOPE.INFO, <http://www.andypope.info/ngs/ng12.htm> (last updated Apr. 28, 2007), and using data from *State Decisions on Health Insurance Marketplaces and the Medicaid Expansion, as of November 22, 2013*, KAISER FAM. FOUND., <http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/> (last updated Nov. 22, 2013).

payments,¹⁰⁴ even in cases in which states have been promised the elimination of federal requirements in exchange for a cap on payment.¹⁰⁵

But the 2014 adult expansion turned out to be different, for reasons that no one close to the process completely understands. It would be easy to ascribe this latest round in Medicaid wars to the uniquely terrible political situation in which the nation finds itself engulfed. It is the case that, over decades of Medicaid expansions, many of the program's most important champions have been federal and state Republican leaders.¹⁰⁶ Indeed, during the halcyon period of Democratic-Republic cooperation in the early days of the ACA's development, staff on both sides considered setting Medicaid coverage standards as high as twice the federal poverty level.¹⁰⁷ This position was abandoned not because of the states, but primarily because insurers themselves, who had insisted on retaining a segmented Medicaid population for risk-avoidance reasons, simultaneously objected to losing out on the just-

104. See, e.g., Bruce Lesley, *Medicaid Block Grants: A Zombie Idea With Lipstick in Texas*, HUFFINGTON POST (Apr. 9, 2013, 5:06 PM), http://www.huffingtonpost.com/bruce-lesley/medicaid-block-grants-texas_b_3044635.html ("Federal block grants are, by definition, an arbitrarily capped amount of federal funding that go to states in the form of a lump sum payment and fail to adjust for population growth, economic changes, public health crises, or natural disasters such as hurricanes, tornadoes, etc.").

105. States are wise, of course. Medicaid is the single largest source of federal funding received by states. See VICTORIA WACHINO ET AL., HENRY J. KAISER FAMILY FOUND., *FINANCING THE MEDICAID PROGRAM: THE MANY ROLES OF FEDERAL AND STATE MATCHING FUNDS*, at i (2004). As the Chief Justice noted in *NFIB*, states are enormously dependent on its funding. While state lawmakers always would appreciate solid funding with fewer requirements, most realize that it is the very structure of the program that justifies the financing arrangement. For a particularly insightful discussion of this stressed and yet mutually beneficial relationship, see Alan Weil, *There's Something About Medicaid*, 22 HEALTH AFF. 13 (2003).

106. See DAVID G. SMITH & JUDITH D. MOORE, *MEDICAID POLITICS AND POLICY, 1965–2007*, at 170–71 (2008) (explaining that the reforms enacted throughout the 1980s, which eventually added coverage of all low-income, pregnant women and children under eighteen years, were the product of consistent and political collaborations among Democrats in the House (chiefly Henry Waxman and John Dingell), Senate Republicans (in particular, Senators Durenberger and Chafee), and two Republican Presidents (Bush and Reagan). However, even fine histories of the era, such as the cited book, do not capture the extent of the collaboration.

107. See *infra* note 108.

above-poverty market.¹⁰⁸ Given the history of federal-state relationships with years of grudging accommodation, the large number of states eager to remove Medicaid's historic exclusion of most poor adults,¹⁰⁹ and the highly favorable federal contribution levels, which begin at 100% federal funding in 2014 and decline to 90% in 2020 and thereafter,¹¹⁰ people basically assumed that the states would come around.

In the end, the catastrophe surrounding the Medicaid expansion probably was the result of a combination of factors: the viciousness of the political environment in which everything can be sacrificed for the sake of scoring points; a persistent and deep bias against aiding poor, uninsured adults (it is not uncommon to find even the most sophisticated reporters referring to the 2014 adult expansion group as “able-bodied,” a dog-whistle term, of course, for the undeserving welfare poor);¹¹¹ and conveniently, a legal theory—coercion—whose very existence was in doubt in the minds of the United States Court of Appeals for the Eleventh Circuit¹¹² but that seems to so aptly sum up the poisonous environment in which the ACA is unfolding. In the end, the coercion doctrine effectively emerged as the weapon of choice for releasing decades of anger about Medicaid requirements and costs, long-standing prejudice against the poor, and capturing in a court of law the extraordinary politics surrounding the Act and its implementation.¹¹³

108. These observations are a result of my direct involvement in the legislative discussions that led to the Act.

109. See, e.g., SAMANTHA ARTIGA, KAISER COMM'N ON MEDICAID & THE UNINSURED, THE ROLE OF SECTION 1115 WAIVERS IN MEDICAID AND CHIP: LOOKING FORWARD AND LOOKING BACK 5 (2009), available at http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/The%20Role%20of%20Section%201118%20Waivers_Mar2009.pdf (discussing different demonstration waiver programs under Medicaid). For example, the George W. Bush Administration established Health Insurance Flexibility and Accountability (HIFA) waivers, special demonstration programs under section 1115 of the Social Security Act, which permitted states to expand coverage to impoverished, but otherwise ineligible, low-income adults. See *id.* at 6–9.

110. See *About Medicaid*, FAMILIESUSA, <http://www.familiesusa.org/issues/medicaid/about-medicaid.html> (last visited Sept. 25, 2013).

111. Pear, *supra* note 21, at A1.

112. See *Florida ex. rel. Attorney Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1265–67 (11th Cir. 2011) (discussing the court's skepticism of the doctrine of coercion).

113. Rosenbaum & Westmoreland, *supra* note 93, at 1671.

Whatever its causes, *NFIB* set off a year-long desperate effort to convince the very states that sued to block the law's implementation to make a 180-degree turn and accept the expansion.¹¹⁴ This odyssey, which will unfold in 2013 and beyond, actually began with a preliminary skirmish in which the states that had sued to block the expansion attempted to stake out new ground that went beyond the decision itself.¹¹⁵ In trying to position themselves on this new ground, the states argued that the Supreme Court actually had altered the terms of the expansion statute itself, creating a series of state options where previously there had been only a single coverage group tied to enhanced funding.¹¹⁶

Eager for the federal funds, states argued that the impact of the decision was to create a partial implementation option (e.g., coverage up to 100% of the federal poverty level, or 50% or whatever percentage a state might choose) at highly favorable federal financial participation rates.¹¹⁷ That the states' position was erroneous was clear from the plain terms of the decision.¹¹⁸ But even had the law been sufficiently ambiguous to afford the Secretary some running room to offer a more expansive interpretation of its meaning, there was widespread skepticism over whether allowing states to select the expansion point of their choice would have done any good as a practical matter.¹¹⁹ States that selected less than all the people in the Medicaid expansion group—persons with family incomes up to 138% of the federal poverty level—might have chosen to cap Medicaid at 100% of poverty, the point at which the Marketplace subsidies actually begin.¹²⁰ But once state flexibility was

114. *Id.* at 1668–71.

115. *Id.* at 1667–70.

116. *Id.*

117. *Id.* at 1669–70.

118. *Id.* at 1668–70 (discussing the decision and the Court's explanation of what it was and was not doing in relation to the Medicaid statute itself).

119. *See, e.g.,* Pear, *supra* note 21, at A1.

120. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1401, 124 Stat. 119 (2010). The fact that the subsidies can commence at 100% of poverty does not alter the fact that Medicaid eligibility, under §1401, bars the receipt of subsidies. *See also* Sara Rosenbaum, *Update: The IRS' Final Shared Responsibility Regulations: When Does Medicaid Eligibility Amount to "Minimum Essential Coverage"?*, HEALTHREFORMGPS (Sept. 4, 2013), <http://www.healthreformgps.org/resources/update-the-irs-final-shared-responsibility-regulations-when-does-medicaid-eligibility-amount-to-minimum-essential-coverage/> (discussing the fact that because the subsidies

granted, there would be no legally logical stopping point, and it was anything but clear that any more states would agree to coverage up to 100% of poverty.¹²¹ This speculation about what might or might not happen were the Secretary to allow states to exercise coverage flexibility within the 2014 expansion group did not matter in any event, because the Court could not have been clearer: its decision did not alter the terms of the expansion population, and therefore could not have given the Secretary the authority to rewrite the legislation.¹²² It merely barred the Secretary's power to withhold current funding from states that refused to adopt it.¹²³

With the prospect of partial expansion officially off the table as the result of Administration policies released in 2012,¹²⁴ state legislatures returned in 2013 to an absolutely extraordinary atmosphere in which the all-or-nothing question of Medicaid expansion was debated in dozens of states.¹²⁵ Legislative sessions in many resister states faced enormous efforts by large stakeholder coalitions in support of

can commence at 100% of poverty does not alter the fact that Medicaid eligibility bars the receipt of subsidies). The ineligibility of persons with other forms of coverage to qualify for premium subsidies represents an attempt on Congress's part to ensure that persons with other forms of coverage would drop their coverage in order to purchase direct coverage through the exchanges instead.

121. Rosenbaum & Westmoreland, *supra* note 93, at 1669.

122. See also Nat'l Fed'n of Indep. Bus. v. Sebelius (*NFIB*), 132 S. Ct. 2566, 2607 (2012) ("This is not to say, as the joint dissent suggests, that we are 'rewriting the Medicaid Expansion.' Instead, we determine, first, that § 1396c is unconstitutional when applied to withdraw existing Medicaid funds from States that decline to comply with the expansion. We then follow Congress's explicit textual instruction to leave unaffected 'the remainder of the chapter, and the application of [the challenged] provision to other persons or circumstances.'" (internal citations omitted)).

123. *Id.*

124. The Secretary quietly announced her decision in a set of "frequently asked questions" (#26) issued December 10, 2012. CTRS. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH & HUMAN SERVS., FREQUENTLY ASKED QUESTIONS ON EXCHANGES, MARKET REFORMS AND MEDICAID 11 (2012) [hereinafter FREQUENTLY ASKED QUESTIONS], available at http://www.tota.org/Files/CMS_FAQ.pdf.

125. See, e.g., *State Legislatures Debate Medicaid Expansion*, PATIENT PROTECTION & AFFORDABLE CARE ACT STATE ACTION NEWSL. (Nat'l Conference of State Legislatures, Denver, Colo.), Feb. 8, 2013, at 1. Debates are ongoing as of Fall 2013. *Several States Still Facing Debates About Medicaid Expansion*, KAISER HEALTH NEWS (Sept. 12, 2013), <http://www.kaiserhealthnews.org/Daily-Reports/2013/September/12/medicaid-expansion-issues.aspx>.

expansion¹²⁶: the health care industry (especially hospitals that treat large numbers of low-income patients and stand to lose tens of billions of dollars in the coming decade in federal Medicare and Medicaid disproportionate share hospital (DSH) payments);¹²⁷ churches and religious organizations;¹²⁸ consumer advocates and voluntary organizations;¹²⁹ and most notably, perhaps, employers¹³⁰—particularly, low-wage

126. See, e.g., Elizabeth Crisp, *Push for Medicaid Expansion Continues Beyond Session*, ST. LOUIS POST-DISPATCH (June 10, 2013), http://www.stltoday.com/news/local/govt-and-politics/article_e17f5e9e-8b5d-5b63-8868-ee10ec8ccada.html#.UbXz1GKKGK34.twitter; Mike Dennison, *Coalition Plans Voter Initiative to Expand Montana Medicaid Coverage*, MISSOULIAN (June 26, 2013, 10:35 AM), http://missoulian.com/news/state-and-regional/coalition-plans-voter-initiative-to-expand-montana-medicaid-coverage/article_c1aa0dd2-de7d-11e2-8a68-0019bb2963f4.html; Mary Ellen Klas, *Big Business Coalitions: Failure to Expand Medicaid Hurts Business*, MIAMI HERALD BLOG (June 19, 2013, 5:06 PM), <http://miamiherald.typepad.com/nakedpolitics/2013/06/big-business-coalitions-failure-to-expand-medicaid-hurts-business.html>.

127. Medicaid Program, State Disproportionate Share Hospital Allotment Reductions, 78 Fed. Reg. 28,551, 28,552 (proposed May 15, 2013) (to be codified at 42 C.F.R. pt. 447); see also 42 U.S.C. § 1395ww(d)(5)(F) (2006 & Supp. V 2011). The DSH cuts are considerable and are slated to take effect despite the fact that many states will not have expanded Medicaid; the cuts were, of course, predicated on the expansion. Corey Davis, *Q and A: Disproportionate Share Hospital Payments and the Medicaid Expansion*, NAT'L HEALTH L. PROGRAM, 6 (July 2012), http://www.apha.org/NR/rdonlyres/328D24F3-9C75-4CC5-9494-7F1532EE828A/0/NHELP_DSH_QA_final.pdf. In the spring of 2013, the Administration attempted to mitigate these effects somewhat in proposed regulations. Medicaid Program; State Disproportionate Share Hospital Allotment Reductions, 78 Fed. Reg. at 28,566; Medicare Program, 78 Fed. Reg. 27,486, 27,504–05 (proposed May 10, 2013) (to be codified at 42 C.F.R. pts. 412, 482, 485, and 489). Whatever softening might be feasible within the confines of the legislative formulas to be applied, it is obvious that the loss of DSH funding will prove especially harmful to hospitals treating large numbers of low-income persons in states that do not expand Medicaid. See Davis, *supra* note 127, at 6. Together, the two reductions are expected to result in more than \$36 billion in losses to these hospitals between 2010 and 2019, and because the reductions are permanent, the losses will continue indefinitely. *Id.* (providing a helpful overview of the two DSH programs and the potential impact of the cuts).

128. See, e.g., JoAnne Viviano, *Religious Groups Push for Kasich's Medicaid Expansion*, COLUMBUS DISPATCH (Mar. 4, 2013, 10:31 AM), <http://www.dispatch.com/content/stories/local/2013/03/04/religious-groups-push-for-kasichs-medicaid-expansion.html>.

129. See, e.g., *About the Alliance*, OHIO ALLIANCE HEALTH TRANSFORMATION, http://ohiomedicaidalliance.org/about_the_alliance (last visited Oct. 5, 2013).

130. See, e.g., Scott Powers, *Business Groups Say Expanding Medicaid Would Save Them Money*, ORLANDO SENTINEL, June 19, 2013,

employers unable to afford health plans for their employees whose workers would qualify for Medicaid coverage.¹³¹ The only force arrayed on the other side of this fight virtually everywhere it was being waged was ideology.

That the expansion arguments have been so one-sided is inevitable in light of the utter absence of any factual basis for turning it down. Indeed, the evidence in favor of the expansion is overwhelming.¹³² Moreover, that state resistance was not based in fact becomes clear from even a cursory perusal of the materials used in the legislative sessions. Even a cursory review of studies from leading research organizations such as the Urban Institute and the Rand Corporation, as well as state-specific studies gauging the economic impact of expansion, illustrates the overwhelming consensus among researchers regarding the bottom-line economic gains to states flowing from the Medicaid expansion, as well as the significant losses that states can be expected to experience as a result of not expanding.¹³³

http://articles.orlandosentinel.com/2013-06-19/news/os-business-pushes-medicaid-expansion-20130619_1_medicaid-expansion-expansion-plan-charity-care.

131. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1513, 124 Stat. 119, 253 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (amending the IRC to include a “shared responsibility for employers” section, also known as “play or pay”). Larger employers that do not offer coverage face tax penalties if their workers purchase subsidized coverage through the Marketplace, but they face no similar penalty if their workers enroll in Medicaid. *Id.* The “shared responsibility” provision will take effect on January 1, 2015. *See Shared Responsibility Requirements*, HEALTHCOVERAGEGUIDE.ORG, <http://healthcoverageguide.org/affordable-care-act/shared-responsibility-requirements/> (last visited Oct. 5, 2013).

132. *See, e.g., Medicaid Expansion Center*, FAMILIESUSA, <http://www.familiesusa.org/issues/medicaid/expansion-center/> (under “Tools to Make the Case for State Expansion”) (last visited Sept. 13, 2013).

133. *See, e.g., JOHN HOLAHAN ET AL., KAISER FAMILY FOUND., THE COST OF NOT EXPANDING MEDICAID* (2013), *available at* <http://kff.org/medicaid/report/the-cost-of-not-expanding-medicaid/>; Carter C. Price & Christine Eibner, *For States That Opt out of Medicaid Expansion: 3.6 Million Fewer Insured and \$8.4 Billion Less in Federal Payments*, HEALTH AFF., June 2013, at 1030; Carter C. Price, *Quick Takes: The Math of Medicaid Expansion*, RAND CORP. (Oct. 21, 2013), <http://www.rand.org/blog/2013/10/quick-takes-the-math-of-medicaid-expansion.html>. Various cost impact studies of the decision to opt out of the Medicaid expansion, a wealth of studies of the various economic benefits of expansion, and state-specific studies on the economic effects of the expansion can be found in a special website maintained by Families USA. *Medicaid Expansion Center*, FAMILIESUSA,

These national studies, as well as the array of specially commissioned reports on the economic impact of the Medicaid expansion that have been prepared for specific states,¹³⁴ document the economic effects of expansion, ranging from its infusion of tens of billions of dollars in revenue into struggling state and local economies¹³⁵ to the assistance that expansion would provide to struggling small low-wage employers¹³⁶ and the property and other tax relief it would provide to strapped local economies bending under the weight of indigent health care costs.¹³⁷

With respect to the Medicaid expansion economic impact analyses, no study has been more important than a special analysis conducted by John Holahan and colleagues in fall 2012 for the Kaiser Family Foundation,¹³⁸ whose central finding is captured in Figure 2, below.¹³⁹ This analysis demonstrates that if all states were to collectively *reject* the Medicaid expansion, they would spend \$8 billion less over the 2013–2022 time-period than would be spent collectively were all states to adopt the expansion.¹⁴⁰ This conclusion rests on several factors: the heavily enhanced federal funding; the effects of the expansion

<http://www.familiesusa.org/issues/medicaid/expansion-center/> (last visited Nov. 12, 2013).

134. These reports and studies can be reviewed at a special website maintained by Families USA, under “Tools to Make the Case for a State Expansion,” *Medicaid Expansion Center*, FAMILIESUSA, <http://www.familiesusa.org/issues/medicaid/expansion-center/> (last visited Sept. 13, 2013), and study collections by state can be viewed under “Resources from the States,” *Medicaid Expansion Center, Resources from the States*, FAMILIESUSA, <http://www.familiesusa.org/issues/medicaid/expansion-center/resources-from-the-states.html> (last visited Sept. 13, 2013).

135. See, e.g., *Medicaid Expansion*, COVER GA., available at http://healthyfuturega.org/pdfs/MedicaidPostcard_r4_web.pdf (last visited Oct. 5, 2013).

136. See, e.g., Steve Spire, *Medicaid Expansion: An Opportunity to Invest in Louisiana's Workforce*, LA. BUDGET PROJECT 1 (2012), available at <http://www.labudget.org/lbp/wp-content/uploads/2012/09/Medicaid-expansion-an-opportunity-to-invest.pdf?b467e680>.

137. See, e.g., Andrea Kovach, *Expanding Medicaid: The Choice is Clear*, SHRIVER BRIEF (July 10, 2012), <http://www.theshriverbrief.org/2012/07/articles/health-care-justice/expanding-medicaid-the-choice-is-clear/>.

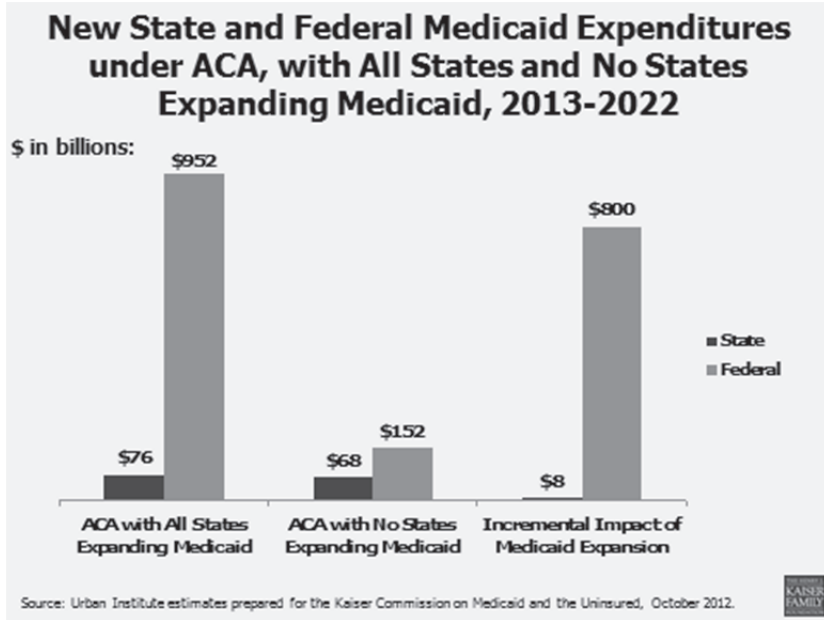
138. JOHN HOLAHAN ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, THE COST AND COVERAGE IMPLICATIONS OF THE ACA MEDICAID EXPANSION: NATIONAL AND STATE-BY-STATE ANALYSIS 5 (2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384.pdf>.

139. *Id.*

140. *Id.* at 1.

on state revenues as funds flow into the economy and jobs; and the expansion's ability to offset, through insurance, previous state and local expenditures on medically indigent care.¹⁴¹

Figure 2



There is, of course, no longer any basis for claiming that health insurance does not matter. A virtual deluge of studies, many captured in the briefs filed with the Court in *NFIB*, documents that the uninsured have more limited access to care and that being uninsured compromises health and life.¹⁴² Nor is there any lingering dispute over the economic impact of the uninsured on the health care system and those with insurance.¹⁴³ While the existence of enormous cost-shifting across health care markets did not create a basis for regulating individual conduct in the health insurance market according to

141. *Id.* at 5–7.

142. *Nat'l Fed'n of Indep. Bus. v. Sebelius (NFIB)*, 132 S. Ct. 2566, 2611–12 (2012).

143. *Id.*

the *NFIB* majority,¹⁴⁴ Congress considered its existence a factual given, along with other evidence showing the economic impact of the failure to extend insurance coverage to all Americans.¹⁴⁵

Neither is there any debate over the value of Medicaid, despite the best efforts of its opponents to attack the program. Medicaid is accused of being costly and ineffective in improving health and health care.¹⁴⁶ In fact, the program owes its size not to excessive spending on the poor, but instead to the sheer number of people it must insure and the costly nature of the services it covers.¹⁴⁷ As an insurer, Medicaid is a bargain, with a price tag one third lower on an average annual per capita basis than the same level of private insurance coverage, chiefly because its provider payment rates are so low.¹⁴⁸ Furthermore, despite claims to the contrary, which themselves rest on flawed research that fails to control for the health characteristics of Medicaid beneficiaries or the point at which they are enrolled in the program,¹⁴⁹ a cascade of studies points in the direction of

144. *Id.* at 2590–93.

145. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1501(a)(2), 124 Stat. 119, 242 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (“Under sections 2704 and 2705 of the Public Health Service Act (as amended by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums.”).

146. *See, e.g.*, Weil, *supra* note 106, at 15.

147. John Holahan & Stacey McMorrow, *Medicare and Medicaid Spending Trends and the Deficit Debate*, 367 NEW ENG. J. MED. 393, 394–95 (2012) (explaining why Medicaid costs so much).

148. *See* CTR. ON BUDGET & POLICY PRIORITIES, EXPANDING MEDICAID A LESS COSTLY WAY TO COVER MORE LOW-INCOME UNINSURED THAN EXPANDING PRIVATE INSURANCE 3 (June 26, 2008), *available at* <http://www.cbpp.org/files/6-26-08health.pdf> (“Average medical costs paid by an insurer on behalf of an adult Medicaid beneficiary would be 7 percent . . . greater on average, if the beneficiary were covered instead by private insurance.”); CBO ESTIMATES, *supra* note 8, at 4–5 (showing that the per capita difference between Medicaid and private premiums is \$6000 versus \$9000).

149. *See* Austin Frakt et al., *Our Flawed but Beneficial Medicaid Program*, 364 NEW ENG. J. MED. e31(1), at e31(1)–(2) (2011) (demolishing arguments made by some researchers that Medicaid is associated with poorer health outcomes).

Medicaid's enormous and positive impact on health and health care among the poor and medically vulnerable.¹⁵⁰

Even as stakeholders sought to make the factual case for expansion, the Administration searched throughout 2013 for possible ways to navigate through the morass. Its first foray, which appeared to persuade few, was to clarify that states could opt out of the expansion, or in the alternative, adopt it and drop coverage later.¹⁵¹ But treating the expansion as temporary raises a host of practical and political difficulties and does not seem to have factored into any state's thinking.

Perhaps the most notable incentives the Administration has dangled have consisted of two strategies. The first has been a promise to consider state coverage and management innovations (accomplished through demonstration waivers under section 1115 of the Social Security Act)¹⁵² as part of an overall expansion strategy.¹⁵³ The Administration has quietly signaled to states that it will consider reforms in benefit design, cost-sharing, freedom of choice, and other aspects of Medicaid administration (for both traditional low-income groups such as parents and children, as well as newly eligible

150. For some of the most recent, and finest, reviews of Medicaid's impact on health, health care, and health care costs, see TERESA A. COUGHLIN ET AL., URBAN INST., ARE STATE MEDICAID MANAGED CARE PROGRAMS READY FOR 2014? A REVIEW OF EIGHT STATES 8–10 (2013), available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf406305 (using national data from the Medical Expenditure Panel Survey to assess the impact of Medicaid on access, health care use, and financial protections for the low income population); see also Katherine Baicker et al., *The Oregon Experiment—Effect of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713, 1718–21 (2013) (finding reductions in depression, improvements in protection against financial catastrophe, but not measurable short-term gains in certain clinical measures of adult health); Benjamin D. Sommers et al., *Mortality and Access to Care Among Adults After State Medicaid Expansions*, 367 NEW ENG. J. MED. 1025, 1029–33 (2012) (finding more generous adult Medicaid eligibility levels associated with reduced mortality from preventable causes).

151. Dylan Scott, *CMS: States Could Adopt Medicaid Expansion, Then Drop It*, GOVERNING (Aug. 6, 2012), <http://www.governing.com/news/federal/gov-cms-no-deadline-for-state-decisions-on-medicaid-expansion.html>.

152. See generally ARTIGA, *supra* note 109 (explaining Affordable Care Act § 1115 Medicaid and CHIP waivers and recommending issues for the Obama Administration to consider).

153. See DEPT OF HEALTH & HUMAN SERVS., FISCAL YEAR 2014 BUDGET IN BRIEF 84 (2013), available at <http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf>.

groups) as part of a state's adult expansion initiative.¹⁵⁴ This approach, which opens the door potentially to slimmer benefits, higher cost sharing, and greater use of structured managed-care arrangements, essentially signals to the states that the Administration is ready to let them significantly restructure Medicaid if the restructuring is carried out in the context of expansion.¹⁵⁵ The hope obviously is that with sufficient "innovation," the growth of the entitlement itself will be seen as more palatable. Indeed, apart from demonstration innovation, the Administration has sought to lure states into greater support for Medicaid through other reforms aimed at granting more leeway in the use of techniques, such as greater cost-sharing, to deter what is perceived as unnecessary or wasteful spending.¹⁵⁶

The strategy that unquestionably has received the most attention has been one that actually makes use of a long-standing state option to use Medicaid funds to purchase private health insurance, but that recast the option in the context of a newly established individual insurance market environment.¹⁵⁷ Under this strategy, the HHS Secretary has clarified that she will make federal funding available to states that elect to enroll some or all low-income beneficiaries into "qualified health plans" (QHPs)¹⁵⁸ sold in Health Insurance Marketplaces¹⁵⁹

154. See generally ROBIN RUDOWITZ & LAURA SNYDER, KAISER COMM'N ON MEDICAID & THE UNINSURED, PREMIUMS AND COST-SHARING IN MEDICAID (2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8416.pdf> (describing the status of premiums and cost-sharing under the AIA); see also Medicaid, Children's Health Insurance Programs, and Exchanges, 78 Fed. Reg. 4594, 4623–29 (Jan. 22, 2013) (to be codified at 42 C.F.R. pts. 430, 431, 433, et al., 45 C.F.R. pt. 155) (discussing the inclusion of new groups and the states' option to be flexible with the Act).

155. Cf. Medicaid, Children's Health Insurance Programs, and Exchanges, 78 Fed. Reg. at 4629–30 (describing states' flexibility in designing benefit packages as part of Medicaid expansion).

156. See *id.* at 4675 ("We believe these proposed policies would encourage less costly care and decreased use of unnecessary services, which may reduce state and federal costs for the specified services."); see also RUDOWITZ & SNYDER, *supra* note 154 (discussing the proposed cost-sharing changes).

157. See Sara Rosenbaum & Benjamin D. Sommers, *Using Medicaid to Buy Private Health Insurance—The Great New Experiment?*, 369 NEW ENG. J. MED. 7 (2013), available at <http://www.nejm.org/doi/full/10.1056/NEJMp1304170>.

158. See *Glossary, Qualified Health Plan*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/qualified-health-plan/> (last visited Oct. 5, 2013).

rather than into traditional Medicaid coverage arrangements—that is, standard fee-for-service coverage or Medicaid-managed care plans.¹⁶⁰

The availability of Medicaid financing to purchase insurance for beneficiaries across all coverage groups is as old as the Medicaid statute itself. The 1965 statute,¹⁶¹ in directing the Secretary to make payments to states to support the cost of medical assistance, defined allowable costs as including state expenditures for both Medicare Part B premiums and “other insurance premiums for medical or any other type of remedial care or the cost thereof . . .”¹⁶² Twenty-five years later, Congress amended the statute to explicitly promote the use of Medicaid to purchase employer-sponsored coverage where available, to the extent that it is cost-effective to do so.¹⁶³ In enacting the employer amendments, Congress also recodified and preserved states’ original broad authority to buy insurance.¹⁶⁴ Today, the definition of medical assistance itself includes explicit permission to states to use federal funds to purchase “other insurance premiums for medical or any other type of remedial care or the cost thereof.”¹⁶⁵

The language from these long-established Medicaid provisions formed the basis for federal guidance issued in late 2012 clarifying the availability of federal funds for premium assistance.¹⁶⁶ The ostensible purpose of the guidance,

159. See generally ROBERT J. HILL ET AL., REED SMITH, ACA AFFORDABLE INSURANCE EXCHANGES AND QUALIFIED HEALTH PLANS (2013), available at http://www.healthindustrywashingtonwatch.com/uploads/file/Alert_Affordable%20Ins%20Exchanges,%20Qualified%20Plans_03_14_2013.pdf (summarizing the structure of the marketplace for qualified health plans).

160. See Rosenbaum & Sommers, *supra* note 157.

161. Health Insurance for the Aged Act, Pub. L. No. 89-97, 79 Stat. 286 (1965).

162. *Id.* § 1903(a)(1).

163. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4402, 104 Stat. 1388 (adding section 1906 to the Social Security Act, 42 U.S.C. § 1396e (2006)). In the employer-sponsored coverage context, the federal government has defined cost-effective as shared premium costs between states and employers. Social Security Act § 1906(e)(2), 42 U.S.C. § 1396e(e)(2) (“The term ‘cost-effective’ has the meaning given that term in section 2105(c)(3)(A).”).

164. See generally Social Security Act Title XIX, 42 U.S.C. §§ 1396–1396v (providing for grants to states for medical assistance programs).

165. Social Security Act § 1905(a), 42 U.S.C. § 1396d(a) (2006 & Supp. V 2011).

166. See FREQUENTLY ASKED QUESTIONS, *supra* note 124, at 15–16.

subsequently mirrored in federal regulations proposed in early 2013,¹⁶⁷ was to offer states a mechanism for potentially reducing health insurance “churn” between Medicaid and the Marketplace, a problem that is estimated to affect some twenty-eight million low-income adults and their families annually as a result of minor fluctuations in household income throughout the year.¹⁶⁸ By purchasing QHP coverage, Medicaid agencies could effectively stabilize enrollment in a coverage arrangement that also serves as the source of coverage in the event that income increases.

As it turned out, the availability of federal Medicaid financing to support premium assistance through the purchase of QHP enrollment had a sufficient ring of the new and sexy about it to at least capture some states’ attention, especially Arkansas.¹⁶⁹ QHP enrollment into the individual market was perceived as having the potential, in other words, to soften opposition among state lawmakers who otherwise would refuse the Medicaid expansion.¹⁷⁰ Furthermore, the purchase of QHP coverage from Marketplace plans has at least the potential to help stabilize Marketplace risk pools since the population most likely to experience churn is younger, low-income workers.¹⁷¹

From a practical point of view, buying QHP coverage probably would differ very little from buying coverage from a Medicaid-managed care plan offering “benchmark” coverage, which consists of the same essential health benefits sold through QHPs, with slightly more cost-sharing protection.¹⁷² At

167. Medicaid, Children’s Health Insurance Programs, and Exchanges, 78 Fed. Reg. 4594, 4624 (Jan. 22, 2013) (to be codified at 42 C.F.R. pts. 430, 431, 433, et al., 45 C.F.R. pt. 155) (describing proposed 42 C.F.R. § 435.1015 premium assistance programs).

168. Sara Rosenbaum, *Medicaid’s Next Fifty Years: Aligning an Old Program with the New Normal*, 6 ST. LOUIS U. J. HEALTH L. & POL’Y 329, 333–34 (2013); see also Benjamin D. Sommers & Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*, 30 HEALTH AFF. 228, 232 (2011).

169. See *Medicaid and the Affordable Care Act: Premium Assistance*, MEDICAID.GOV, <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf> (last visited Oct. 20, 2013) (discussing Arkansas specifically in CMS’s Q&A).

170. *Id.*

171. See *id.* (discussing the characteristics of new enrollees).

172. See *id.*; Nat’l Council for Cmty. Behavioral Healthcare, *Medicaid Benchmark Benefits in Health Reform: Improvements and Exemptions*, THENATIONALCOUNCIL.ORG, <http://homeless.samhsa.gov/ResourceFiles/>

the same time, a QHP purchasing strategy would resolve a problem confronting the fifteen states that still do not have a well-developed Medicaid-managed care industry,¹⁷³ namely, what to do with millions of newly insured people who cannot enroll into any organized care system with a functional provider network in these states (indeed, Arkansas offers a case in point¹⁷⁴). Viewed in this way, a strategy of using Medicaid as premium support for QHP enrollment resolves a complex operational problem.¹⁷⁵ Of course, it is not possible to say how many issuers and their provider networks will be willing to cross over and sell in the Medicaid market. But a number of Medicaid-managed care companies appear to be eager to move into the QHP market,¹⁷⁶ and so the prospects for multi-market plans may be decent in those states with Medicaid managed care already in place. In states that have no managed-care experience such as Arkansas, the potential for market growth—assuming that the state focuses its premium support on younger, healthier working populations—would appear to be good.¹⁷⁷

To further the use of premium support, the Administration has clarified in guidance that its premium assistance policy is intended for use in the case of beneficiaries who qualify for Medicaid based on low family income rather than medical frailty,¹⁷⁸ and furthermore, that enrollment in private coverage must be voluntary for beneficiaries unless the use of premium assistance (a state option) is coupled with a time-limited, Section 1115 compulsory-enrollment demonstration waiver.¹⁷⁹ Proposed premium assistance regulations issued in January

Medicaid%20Benchmark%20Coverage%20Health%20Reform.pdf (last visited Oct. 20, 2013).

173. COUGHLIN ET AL., *supra* note 150, at 2 (“In 2010, all but 15 states had comprehensive risk-based Medicaid managed care programs . . .”).

174. Sarah Kliff, *Arkansas’s Unusual Plan to Expand Medicaid*, WASH. POST WONKBLOG (Feb. 28, 2013, 3:24 PM), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/02/28/arkansas-different-plan-to-expand-medicaid/>.

175. *Cf. Medicaid and the Affordable Care Act: Premium Assistance*, *supra* note 169.

176. *See* COUGHLIN ET AL., *supra* note 150, at 6 (“Many, but not all, of the managed care health plans interviewed for this study suggested that they would participate in their state’s Exchange.”).

177. Rosenbaum, *supra* note 168, at 344–45.

178. *Medicaid and the Affordable Care Act: Premium Assistance*, *supra* note 169.

179. *Id.*

2013 as part of a larger set of Medicaid regulations¹⁸⁰ stipulate four conditions on the use of Medicaid to finance premium assistance in the context of the ACA,¹⁸¹ all of which are intended to foster the integration of expanded Medicaid coverage with Marketplace coverage in order to foster alignment between two markets and reduce the potential for inter-market churning.¹⁸² First, the insurance coverage must be primary to Medicaid in terms of coverage, with Medicaid acting as the primary payer only for items and services not falling within the essential health-benefit package that all QHP issuers must furnish.¹⁸³ Second, because Medicaid beneficiaries enrolled in private insurance nonetheless remain Medicaid beneficiaries, states must continue to provide beneficiaries with the full scope of Medicaid coverage for items and services falling outside the essential health-benefit package but covered under the state plan.¹⁸⁴ Third, states must adhere to Medicaid's special cost-sharing protections, which are more generous than those established for Marketplace-subsidized plans.¹⁸⁵ Finally, and perhaps most significant from an operational perspective, the proposed rule specifies that "[t]he cost of purchasing such coverage, including administrative expenditures and the costs of providing wraparound benefits for items and services covered under the Medicaid State Plan, but not covered under the individual health plan, must be comparable to the cost of providing direct coverage under the State plan."¹⁸⁶

Although states' authority to use premium assistance is clear, the Administration's proposed premium assistance policy raises a number of implementation issues.¹⁸⁷ First, must health plans purchased using a premium-support approach comply with all federal and state requirements applicable to the

180. FFP for Premium Assistance for Plans in the Individual Market, 78 Fed. Reg. 4594, 4696 (proposed Jan. 22, 2013) (to be codified at 42 C.F.R. § 435.1015).

181. *Id.* (disclosing the four conditions for financing premium assistance in proposed 42 C.F.R. § 435.1015(a)(1)–(4)).

182. Rosenbaum, *supra* note 168, at 334.

183. *See* FFP for Premium Assistance for Plans in the Individual Market, 78 Fed. Reg. at 4696.

184. *Id.* (describing proposed § 435.1015(a)(2)).

185. *Id.* (describing proposed § 435.1015(a)(3)).

186. *Id.* (describing proposed § 435.1015(a)(4)).

187. *See* Rosenbaum, *supra* note 168, at 334.

purchase of traditional managed-care plans?¹⁸⁸ Although the requirements applicable to Medicaid-managed care are similar, they are not identical.¹⁸⁹ Does a premium-support agreement trigger the full complement of Medicaid conditions applicable to managed care arrangements?

Second, how is the comparability of costs to be measured? As noted, the CBO cost estimates make clear that covering Medicaid beneficiaries through premium support will cost 50% more than traditional coverage.¹⁹⁰ The basis for this difference is pretty obvious: if agencies buy insurance, they are paying premiums. They also are buying into coverage arrangements that tend to pay significantly higher provider fees.¹⁹¹ Given the obviously higher costs associated with private insurance, it is unclear how the comparability test can ever be satisfied. In Arkansas's case, the state has suggested that its providers actually get paid by private insurers at rates not much higher than Medicaid.¹⁹² The state also has attempted to calculate the administrative savings that can be expected to flow from reduced churning,¹⁹³ but the level of savings that can be achieved in relation to the added costs associated with enrollment in private insurance is unclear. Furthermore, the nominal costs associated with buying pricier coverage would rise further if the purchase of QHP policies stabilizes coverage

188. *See id.* at 344–45.

189. *See id.*

190. *See* CBO ESTIMATES, *supra* note 8, at 4.

191. *See* AETNA, UNDERSTANDING HOW THE HEALTH INSURANCE PROVIDERS FEE AND TRANSITIONAL REINSURANCE CONTRIBUTION WILL AFFECT YOU 3–4 (2013), *available at* http://www.aetna.com/health-reform-connection/documents/Aetna_HIP_RC_Brochure_FINAL.pdf.

192. *See* Jay Hancock, *The Arkansas Medicaid Model: What You Need to Know About the 'Private Option'*, KAISER HEALTH NEWS (May 1, 2013), <http://www.kaiserhealthnews.org/stories/2013/may/02/arkansas-medicaid-private-option-faq.aspx>; Kliff, *supra* note 174.

193. *See* MARYBETH MUSUMECI, KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID EXPANSION THROUGH PREMIUM ASSISTANCE: KEY ISSUES FOR BENEFICIARIES IN ARKANSAS' SECTION 1115 DEMONSTRATION WAIVER PROPOSAL 6 (2013), *available at* <http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8459-medicaid-expansion-through-premium-assistance.pdf> (“Arkansas’ proposal states that it seeks to alleviate coverage gaps and differences in benefits and provider networks as individuals move back and forth between Medicaid and Marketplace coverage due to changes in income.”).

over time.¹⁹⁴ Reduced churning improves coverage stability, but eliminating the on-off quality of insurance could be expected to result in additional costs.¹⁹⁵ Over the 2014–2016 time period, when the federal contribution is at 100%, the additional costs associated with premium support would be borne fully by the federal government in the case of newly eligible beneficiaries.¹⁹⁶ States would begin to incur costs after this date.¹⁹⁷ Moreover, to the extent that premium support is extended to traditional low-income populations not covered by the enhanced payment (e.g., low-income parents and their minor children), the federal contribution would be at the regular level, and the states' share accordingly would be higher.¹⁹⁸ Whether these higher costs are enough to dissuade states from attempting premium support remains an unknown. Regardless of the questions raised by premium assistance, it would seem obvious that the value of allowing states to move forward in this fashion outweighs the challenges if the added flexibility is sufficient to encourage states to adopt the expansion.

IV. DISCUSSION

The future of the Affordable Care Act rests on the extent to which two federalism relationships succeed. The first relationship, codified in the Public Health Service Act, establishes a regulatory partnership between the federal and state governments that covers the health insurance industry as a whole, as well as the special new Marketplaces for affordable insurance.¹⁹⁹ Clearly, this relationship is not without its

194. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1402, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

195. In the short term it is always less expensive to interrupt coverage for weeks if not months, since during the interruption periods, insured services are not consumed. During the health reform debate, annual enrollment periods were considered and rejected for cost reasons. In 2013, legislation was introduced by Representatives Green and Barton to enable states to use annual enrollment periods. Stabilize Medicaid and CHIP Coverage Act, H.R. 1698, 113th Cong. § 3 (2013).

196. HOLAHAN ET AL., *supra* note 138, at 36.

197. *Id.*

198. *Medicaid and the Affordable Care Act: Premium Assistance*, *supra* note 169.

199. See generally Public Health Service Act, 42 U.S.C. §§ 300gg to 300gg–28 (discussing requirements relating to health insurance coverage).

complications, and its success turns on a delicate dance between the partners over questions of standards and enforcement.²⁰⁰ Despite the bumps and delicacy, the key value of the relationship is that if the state partner fails, the federal government is empowered to act, typically to nudge the state partner into action, but if necessary, to assure that national standards actually operate as national standards.²⁰¹

The second partnership, codified in Medicaid, can be thought of as a joint investment relationship. This relationship is much more long-lived with decades of bumpiness, but it has never hit quite the same level of rock bottom that has been reached in half the states under the ACA. From the time of Medicaid's enactment it has been obvious that having to rely on state choices for covering the poor creates real problems; by their failure or refusal to invest, states had the power to dramatically reduce the program's reach and investment.²⁰²

Now, however, the problem has become critical. On January 1, 2014, a transformational era in U.S. health policy is set to begin when near-universal coverage is scheduled to commence.²⁰³ At the rate things are going, the transformation will be aborted in half of all states.²⁰⁴ In community after community, outreach efforts will produce hundreds and thousands of applicants who, given the realities of who is uninsured, will be especially likely to have such low household income that they will qualify for Medicaid.²⁰⁵ Indeed, regardless of whether one uses the initial CBO coverage projections or its more recent updated estimates, it is clear that

200. *See id.*

201. *See* 42 U.S.C. § 300gg-22.

202. *Cf.* Rosenbaum, *supra* note 25, at 27-28 ("The federal Medicaid law traditionally vests states with significant discretion over who will be covered, what benefits will be provided, what providers will be allowed to participate in the program, how providers will be regulated and paid for their services, and how states' plans will be administered. The majority of state Medicaid expenditures are for services considered optional under federal law.")

203. *See* KATIE KEITH ET AL., THE COMMONWEALTH FUND, IMPLEMENTING THE AFFORDABLE CARE ACT: STATE ACTION ON THE 2014 MARKET REFORMS 1 (2013), available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2013/1662_Keith_implementing_ACA_state_action_2014_reform_brief_v2.pdf.

204. *Cf. id.* at 5-8 (finding that thirty-nine states have yet to pass legislation to implement the 2014 market reforms, though several states are considering related legislation).

205. *See* Rosenbaum, *supra* note 168, at 330.

Medicaid accounts for half of the entire new enrollment under the law.²⁰⁶ States' failure to adopt the expansions means that in these communities, a sizable number of applicants promised "no wrong door" (the parlance during health reform to signal near-universal availability of coverage) will find their applications rejected because they are too poor.²⁰⁷

In the absence of a miraculous turn-around between the middle and the end of 2013, it is too late to hope for anything other than stories of widespread coverage denials. No one thought about a federal fallback, because federal policymakers were convinced as a matter of law that none was needed. The Supreme Court's decision changed everything in this regard and made it essential to think about fallback approaches, assuming that future legislative reforms do become possible.

What might a federal Medicaid fallback look like? Obviously, the fallback cannot involve the forced expenditure of funds by states on behalf of the newly eligible population without crossing the line into coercion. Nor can the fallback involve simply improving the incentives. Even if the enhanced federal funding were to be set at 100% permanently rather than declining slightly over time,²⁰⁸ a heightened payment would not suffice; in their cost estimates and court filings, state officials have actively argued that the enhanced federal-financing formula is inadequate in two respects.²⁰⁹ First, they point out, the formula does not provide 100% contributions for administrative costs associated with the expansion, which may be considerable.²¹⁰ Second, they note that the 100% contribution rate does not apply to offset costs associated with health reform's "woodwork" effects, that is, costs associated with covering individuals who would have qualified for Medicaid under pre-expansion program rules and had never applied for help but did so in 2014 as a result of expanded

206. See Ku, *supra* note 88.

207. See Ellie Sandmeyer, *WSL Cherry-Picks Study to Attach Medicaid Expansion*, *MEDIAMATTERS AM.* (Oct. 9, 2013), <http://mediamatters.org/print/research/2013/10/09/wsj-cherry-picks-study-to-attack-medicaid-expan/196368>.

208. See CBO ESTIMATES, *supra* note 8, at 9.

209. See STAN DORN, URBAN INST. HEALTH POLICY CTR, *CONSIDERATIONS IN ASSESSING STATE-SPECIFIC FISCAL EFFECTS OF THE ACA'S MEDICAID EXPANSION 2* (2012), available at <http://www.urban.org/UploadedPDF/412628-Considerations-in-Assessing-State-Specific-Fiscal-Effects-of-the-ACAs-Medicaid-Expansion.pdf>.

210. *Id.* at 2-3.

outreach efforts.²¹¹ Whether these underestimates of the cost of expansion are correct, the point is that simply increasing the incentive for expansion is insufficient, not only because additional costs may accrue but because so much of the resistance now in evidence can be attributed to ideology devoid of factual basis. The facts in this case simply do not explain the behavior that is on display.

Fashioning a federal Medicaid fallback in a post-reform world becomes far more feasible than previously, precisely because the ACA builds a companion, subsidized individual insurance market that is accessible regardless of health status,²¹² has a mechanism for adjusting the cost of coverage by family income,²¹³ and offers a level of coverage that, although not as enriched as Medicaid, is broad.²¹⁴ Marketplace products will cover a full range of preventive services without cost sharing.²¹⁵ Cost-sharing assistance will be available for other covered items and services.²¹⁶ And covered items and services will be comparable to that found in the small-group market, and special protections such as mental health parity and bans against discrimination in coverage based on disability will apply.²¹⁷ To be sure, this level of coverage does not suffice for

211. *Id.* at 3. For a discussion of estimating the proportion of Medicaid-eligible children and adults who are not enrolled, see generally BEN SOMMERS ET AL., DEPT OF HEALTH & HUMAN SERVS., UNDERSTANDING PARTICIPATION RATES IN MEDICAID: IMPLICATIONS FOR THE AFFORDABLE CARE ACT (2012), available at <http://aspe.hhs.gov/health/reports/2012/medicaidtakeup/ib.pdf>. Estimates are that only half of all Medicaid-eligible adults actually were enrolled prior to the ACA, with state estimates ranging from 36% in Mississippi to 81% in Massachusetts. *Id.* at 3.

212. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1201, 124 Stat. 119, 154 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (prohibiting preexisting condition exclusions).

213. See generally KAISER FAMILY FOUND., EXPLAINING HEALTH CARE REFORM: QUESTIONS ABOUT HEALTH INSURANCE SUBSIDIES (2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7962-02.pdf> (describing scaled tax credits based on family income).

214. See, e.g., Patient Protection and Affordable Care Act § 1302, 124 Stat. at 163 (requiring coverage for essential health benefits).

215. *Id.* § 1001, 124 Stat. at 130 (amending PHSA section 2713 regarding the coverage of preventive health services).

216. See, e.g., *id.* § 1513, 124 Stat. at 253 (providing for shared responsibility for employers regarding health coverage and discussing cost sharing).

217. *Id.* § 1302(b)(4)(D), 124 Stat. at 164 (“[T]he Secretary shall—ensure that health benefits established as essential not be subject to denial to

children and adults with serious, long-term health needs, but the people most likely to be injured by the nonexpansion states are, to a significant degree, very poor workers.²¹⁸ Even individuals with more advanced health needs would be helped—although not as much as they might need—by Marketplace products. Finally, because the ACA contains provisions for risk adjustment across the insurance market in order to ensure that adverse selection into qualified health plans sold in the Marketplace does not sink it,²¹⁹ using QHP coverage as a fallback for the poorest individuals becomes even more feasible.

Two models of the fallback might be considered. In the first, the federal government would simply assume 100% responsibility for all newly eligible individuals and enroll them in qualified health plans. In the second, the federal government could offer states the option of managing coverage for the expansion group, just as they manage their state plans generally, but reimburse states 100% permanently for costs associated with this group. In this way, those states that do wish to expand, as half have done, would continue to play the primary role in coverage and administration. But as with the Public Health Service Act, states that do not wish to administer the coverage expansion could opt for federal administration, just as states can opt for a federal Marketplace or federal management of insurance reforms today.

Of course, nothing gets done in Washington by way of investment if there is no source of financing. Two sources come to mind to cover the cost of a complete federalization of the expansion costs. One source might be a small reduction of federal funds otherwise payable for current Medicaid programs. While the federal government could not require states to pay their own funds to add the new expansion group, there is no reason, under coercion theory, why the federal government could not slightly alter the terms of its current contribution to state programs. The federal contribution to Medicaid

individuals against their wishes on the basis of the individuals' . . . present or predicted disability . . .").

218. See Michelle F. Cortez, *Push Against Obamacare Leaves 5 Million Without Coverage*, BLOOMBERG (Oct. 17, 2013, 11:01 PM), <http://www.bloomberg.com/news/2013-10-17/push-against-obamacare-leaves-5-million-without-coverage.html>.

219. Patient Protection and Affordable Care Act § 1343, 124 Stat. at 212.

constantly rises and falls as state circumstances change and as broader economic conditions evolve. Since the federal government has already committed to 90% federal contribution to the expansion population in perpetuity, the reduction on contributions to current state programs would be quite modest.²²⁰

Another source of funding might be a further expansion of the so-called “Cadillac tax,”²²¹ that is, the additional tax that will be paid by health plans considered to have excessive value under the Act. Currently, the tax is set to hit plans, beginning in 2018, with a value of \$10,200 in the case of individual plans and \$27,500 in the case of family coverage.²²² The tax threshold could be lowered slightly in order to help offset the increment necessary to increase federal financing for the newly eligible group to 100%. Other possible sources of revenue might be a slight increase in the medical device tax or a tax on insurers themselves.

Perhaps states eventually will come around, especially once they actually start to face the financial, social, and moral consequences in 2014 of having excluded their own residents from health reform. It is also true that the lack of a federal fallback to compensate for low Medicaid coverage has always been one of Medicaid’s most serious problems, and no solution previously has been devised. However, health reform raises the ante, not only by intensifying the pain of state choices but also by creating the potential for a thoroughly workable fallback in the event that states do not expand. We owe it to ourselves as a nation, not to mention to the poor, to at least try.

220. See, e.g., Sandhya Somashekhar, *GOP Governors’ Endorsements of Medicaid Expansion Deepen Rifts Within Party*, WASH. POST, June 3, 2013.

221. See Patient Protection and Affordable Care Act § 9001, 124 Stat. at 847 (imposing an excise tax on high cost employer-sponsored health coverage); Reed Abelson, *Bearing Down on Health Costs*, N.Y. TIMES, May 28, 2013, at B1. There is some evidence to suggest that high value health plans already are being scaled back in order to avoid the tax, so the value of increasing tax liability might fade over time. Abelson, *supra*, at B1.

222. Abelson, *supra* note 221, at B1.
