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THE AFFORDABLE CARE ACT'S  
OPTIONAL MEDICAID EXPANSION:  
Considerations Facing State Governments

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Charles Blahous



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## ABSTRACT

IN THE WAKE of a 2012 Supreme Court ruling, states face complex decisions concerning whether to expand Medicaid coverage as specified in the Affordable Care Act (ACA). With the federal government no longer able to coerce expansion, states must base their decisions on subjective value judgments that will vary from state to state, incorporating each state's unique budgetary circumstances, the needs of its uninsured population, and the incentives established by interactions between the ACA's provisions. A first important consideration is that states face substantial near-term Medicaid cost increases irrespective of coverage expansion decisions. Second, unless federal subsidies for health exchanges are reduced substantially relative to current law, states face a common incentive to decline to cover childless adults with incomes above the federal poverty level under Medicaid. Third, states face more complicated decisions over whether to cover childless adults with incomes below this level under Medicaid, though a recent Department of Health and Human Services announcement weakens their incentives to do so. States must also factor in the strong likelihood that future federal support for Medicaid will be constrained relative to current law projections. Many states will thus find it prudent to defer their decision-making for as long as possible.

*JEL* codes: I11, I13, I18

## I. INTRODUCTION: MEDICAID BEFORE THE AFFORDABLE CARE ACT

ONE OF THE primary objectives of the comprehensive health reform legislation enacted in 2010 (the Affordable Care Act, or ACA) was to considerably expand US health insurance coverage and to subsidize that expansion with federal funds. Federal lawmakers chose the preexisting Medicaid program as the ACA's main vehicle of expanding both coverage and subsidies for the previously uninsured poor.

Medicaid is a complex amalgam of federal and state government activity. The program is established in federal law while state participation is technically optional, though all states participate. Federal law establishes minimum standards for the health insurance coverage individuals must receive under state Medicaid plans, as well as certain individual participant eligibility criteria. The law has long mandated that participating states cover specific needy and vulnerable populations, while expressly giving states the option of covering others. Mandatory coverage populations have included “pregnant women and children under age 6 with family incomes at or below 133% FPL [the federal poverty limit], children ages 6 through 18 with family incomes at or below 100% FPL, parents and caretaker relatives who meet the financial eligibility requirements for the former AFDC (cash assistance) program, and elderly and disabled people who qualify for Supplemental Security Income benefits based on low income and resources.”<sup>1</sup> Optional coverage populations have included many in these same demographic groups but with higher incomes, as well as certain “medically needy” individuals, among others.<sup>2</sup> Notable

1. Henry J. Kaiser Family Foundation, “A Guide to the Supreme Court’s Affordable Care Act Decision,” July 2012, <http://www.kff.org/healthreform/upload/8332.pdf>. See also Kaiser Commission on Medicaid and the Uninsured (Kaiser Commission), “Federal Core Requirements and State Options in Medicaid,” April 2011, <http://www.kff.org/medicaid/upload/8174.pdf>; Social Security Act, 42 U.S.C. § 1396a, “State Plans for Medical Assistance,” [http://ssa.gov/OP\\_Home/ssact/title19/1902.htm#act-1902-a-10-a-i](http://ssa.gov/OP_Home/ssact/title19/1902.htm#act-1902-a-10-a-i). Most federal publications appear to refer to the FPL as the federal poverty level, as at <http://aspe.hhs.gov/poverty/11poverty.shtml>; the word “limit” is used here (and later in this study) because it appears as part of a quotation.
2. Kaiser Commission, “Federal Core Requirements.” See also Social Security Act, “State Plans for Medical Assistance”; Social Security Act, 42 U.S.C. § 1396b, “Payment to States,” [http://ssa.gov/OP\\_Home/ssact/title19/1903.htm](http://ssa.gov/OP_Home/ssact/title19/1903.htm); and Social Security Act, 42 U.S.C. § 1396d, “Definitions,” [http://ssa.gov/OP\\_Home/ssact/title19/1905.htm](http://ssa.gov/OP_Home/ssact/title19/1905.htm).

absences from these covered populations historically have included many childless adults below or near the FPL.

Federal Medicaid law prescribes minimum benefit and eligibility standards for each state Medicaid plan, leaving it to the federal secretary of Health and Human Services (HHS) to determine whether a state is in compliance with them. The federal government has provided financing for compliant state Medicaid plans according to a statutory formula known as the Federal Medical Assistance Percentage (FMAP). In sum, the Medicaid program is a complex partnership in which states receive funding support from the federal government, and this funding comes to the states with a complicated set of federal stipulations and requirements.

The FMAP varies by state and is a function of average individual income levels within each one; the lower the per capita income within the state, the greater the proportion of federal assistance. The statute has also specified that no state's FMAP can be lower than 50 percent or higher than 83 percent of applicable Medicaid costs. Historically, the federal government has picked up 57 percent of Medicaid costs on average, with states financing the remaining 43 percent.<sup>3</sup> The federal share was temporarily increased in 2009 stimulus legislation that provided substantial short-term federal assistance to the states.<sup>4</sup> FMAPs as of fiscal year 2008 are shown in table 1.

If a state fails to comply with federal Medicaid law's benefit and eligibility requirements, the HHS secretary is empowered to cut off federal financing support. Specifically, the law states that "the Secretary shall notify such State agency that further payments will not be made to the State . . . until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is satisfied he shall make no further payments to such State."<sup>5</sup>

Despite the general applicability of federal law's basic Medicaid eligibility criteria, coverage levels have varied significantly from state to state. This is not only because of each state's statutory flexibility to cover those in "optional" coverage categories, but because other aspects of Medicaid law have permitted states to somewhat tailor their degree of coverage to their respective policy preferences. Section 1115 of the Social Security Act, for example, allows the HHS secretary to waive the eligibility parameters of general Medicaid law if he concludes that doing so is "likely to assist in promoting the objectives" of Medicaid.<sup>6</sup> Many states have

3. Centers for Medicare & Medicaid Services (CMS), "2011 Actuarial Report on the Financial Outlook for Medicaid," <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/MedicaidReport2011.pdf>. There are separate FMAP rates for administrative costs. See Kaiser Commission, "Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)," September 2012, <http://www.kff.org/medicaid/upload/8352.pdf>.
4. American Recovery and Reinvestment Act of 2009, § 5001, 111th Cong. (2009), <http://www.gpo.gov/fdsys/pkg/BILLS-111hr1enr/pdf/BILLS-111hr1enr.pdf>.
5. Social Security Act, 42 U.S.C. § 1396c, "Operation of State Plans," [http://ssa.gov/OP\\_Home/ssact/title19/1904.htm](http://ssa.gov/OP_Home/ssact/title19/1904.htm).
6. Social Security Act, 42 U.S.C. § 1315, "Demonstration Projects," [http://ssa.gov/OP\\_Home/ssact/title11/1115.htm](http://ssa.gov/OP_Home/ssact/title11/1115.htm).

TABLE 1. FEDERAL MEDICAL ASSISTANCE PERCENTAGES, FY 2008

STATE	FMAP		
Alabama	67.62	Montana	68.53
Alaska	52.48	Nebraska	58.02
Arizona	66.20	Nevada	52.64
Arkansas	72.94	New Hampshire	50.00
California	50.00	New Jersey	50.00
Colorado	50.00	New Mexico	71.04
Connecticut	50.00	New York	50.00
Delaware	50.00	North Carolina	64.05
Florida	56.83	North Dakota	63.75
Georgia	63.10	Ohio	60.79
Hawaii	56.50	Oklahoma	67.10
Idaho	69.87	Oregon	60.86
Illinois	50.00	Pennsylvania	54.08
Indiana	62.69	Rhode Island	52.51
Iowa	61.73	South Carolina	69.79
Kansas	59.43	South Dakota	60.03
Kentucky	69.78	Tennessee	63.71
Louisiana	72.47	Texas	60.56
Maine	63.31	Utah	71.63
Maryland	50.00	Vermont	59.03
Massachusetts	50.00	Virginia	50.00
Michigan	58.10	Washington	51.52
Minnesota	50.00	West Virginia	74.25
Mississippi	76.29	Wisconsin	57.62
Missouri	62.42	Wyoming	50.00

Source: US Department of Health and Human Services, "Federal Percentages and Federal Medical Assistance Percentages, FY 1961–2011," <http://aspe.hhs.gov/health/fmapearly.htm>.

thus negotiated with the federal government to allow them to cover other populations beyond those specified in Medicaid law while still receiving the majority of their financing from the federal government.<sup>7</sup>

## II. EXPANSION OF MEDICAID UNDER THE AFFORDABLE CARE ACT

THROUGH THE ENACTMENT of the ACA, federal lawmakers sought to considerably expand the numbers of those insured by Medicaid. The ACA added a large category of individuals to those that a state Medicaid program must cover: essentially all those with incomes below 133 percent of the FPL who were not previously eligible. Such individuals were to be covered under Medicaid beginning on January 1, 2014. With the law also providing for an income exclusion equal to 5 percent of the FPL, the ACA effectively expanded Medicaid eligibility to those with an income lower than 138 percent of the FPL.<sup>8</sup>

In combination with the aforementioned provision of law that empowers the HHS secretary to withhold further Medicaid payments to noncompliant states, the ACA as a whole threatened states with the loss of their existing federal Medicaid funding if they did not proceed to cover all those with incomes below 138 percent of the FPL. At the same time, the ACA sought to provide the states, whose participation in Medicaid remained technically voluntary, with a powerful positive financial inducement to expand coverage. The ACA specified that the FMAP for “newly eligible” individuals would be 100 percent for the years 2014 to 2016, then gradually decline to 90 percent in 2020 and afterward. This language effectively stipulates that the federal government will pick up most but not all the costs of the ACA’s intended Medicaid expansion. The federal government will pay a far higher percentage of the cost of covering those who are newly eligible than it will pay for those covered to date.

After the ACA was passed and before the Supreme Court ruled on its constitutionality, federal government scorekeepers assumed that all states would comply

7. States that covered childless adults prior to the passage of the ACA are often referred to as “expansion states.” Massachusetts and Vermont have covered childless adults with incomes in excess of 133 percent of the FPL through Section 1115 waivers. Arizona, Hawaii, Delaware, Maine, and New York used Section 1115 waivers to cover childless adults but did not extend coverage all the way to 133 percent of the FPL. Kaiser Commission, “Medicaid Coverage and Spending in Health Care Reform,” May 2010, <http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf>. Another waiver provision is Section 1915(b), which permits states to apply for “waivers to provide services through managed care delivery systems.” See “Waivers,” <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>. Some of the states that have expanded coverage populations beyond minimum requirements have also received waivers to enroll some high-need individuals in managed care. See Kaiser Commission, “An Overview of Recent Section 1115 Medicaid Demonstration Waiver Activity,” May 2012, <http://www.kff.org/medicaid/upload/8318.pdf>.
8. CMS, “2011 Actuarial Report.”



with the full Medicaid expansion.<sup>9</sup> Beyond the issue of the states' financial calculus associated with the expansion, the ACA appeared to wield a heavy compliance stick in the aforementioned threat of the loss of existing Medicaid funding for states that did not comply. The combination of the ACA's mandate and its enforcement created the expectation that state participation would be total.

In March 2012, the Congressional Budget Office (CBO) projected that the ACA's Medicaid coverage expansion would result in 17 million additional nonelderly adults being added to the Medicaid rolls by 2022, on top of a base prior-law projection of 32 million enrollees—an increase in Medicaid coverage of over 50 percent.<sup>10</sup> In the same report, the CBO projected that the coverage expansion would result in \$931 billion in additional federal expenditures for Medicaid and the Children's Health Insurance Program (CHIP) in the years 2014 to 2022 alone.<sup>11</sup>

### III. THE 2012 SUPREME COURT DECISION

IN JUNE 2012, the US Supreme Court ruled on the constitutionality of the ACA. In an important ruling that extends beyond the scope of this study, a majority of the court found that the ACA's core requirement that individuals carry health insurance, though “not a valid exercise of Congress's power under the Commerce Clause,” was nevertheless constitutional if interpreted as levying a tax on those without health insurance.<sup>12</sup> While this ruling allowed the implementation of much of the ACA, in the same decision the Supreme Court struck down the federal government's power to enforce the ACA's mandatory Medicaid coverage expansion.

Chief Justice John Roberts's opinion noted that 42 United States Code 1396c empowered the federal government to take away states' existing Medicaid funding if they chose not to participate in its expansion. The chief justice referred to this penalty as “economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion.” He found the “dragooning” to be an unconstitutional violation of state prerogatives that would be “fully remedied

9. One example is CMS, “2011 Actuarial Report,” 25, which states that “eligibility will be expanded to almost all persons under age 65 in families with income below 138 percent of the Federal Poverty Level (FPL).” Congressional Budget Office (CBO) projections reflect the same implicit assumptions, as in CBO, “Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act,” March 2012.
10. CBO, “Updated Estimates.”
11. *Ibid.* The vast majority of this combined spending is in Medicaid proper, as distinct from CHIP. In 2011, the CBO estimated that nearly 97 percent of the combined spending on the two related programs was for Medicaid. CBO, “Medicaid and CHIP,” <http://www.cbo.gov/topics/health-care/medicaid-and-chip>.
12. Supreme Court of the United States, *Syllabus, National Federation of Independent Businesses et al. v. Sebelius*, 2. Technically, the finding rested on two different court majorities; the majority of the court that concluded that the purchase mandate was an unconstitutional application of the Commerce Clause was different from the majority of the court that concluded that it was constitutional if interpreted as a tax.

by precluding the Secretary [of HHS] from applying 1396c to withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion.”<sup>13</sup> The rest of the ACA was left standing virtually intact.

The Supreme Court’s decision effectively left the ACA’s ambitious Medicaid expansion subject to individual state decisions. Simply put, the court took away the federal government’s stick but left the ACA’s carrot in place. The federal government could not force the states to expand Medicaid by denying them their existing Medicaid funding if they declined. Nor could it force states that chose to expand to do so according to the ACA’s specific expansion schedule. Left intact, however, was the ACA’s inducement: the generous federal match rate—100 percent in the first three years and 90 percent over the long term—applied to the Medicaid coverage expansion. The court’s decision soon brought into focus a critical question: Would all the states aggressively expand Medicaid per the terms of the ACA now that it was no longer compulsory?

#### IV. PRELIMINARY DATA ON STATE ATTITUDES AND INCENTIVES FOR MEDICAID COVERAGE EXPANSION

ALMOST AS SOON as the Supreme Court’s decision was published and read, opinions were voiced as to whether the states should and would participate in the now-optional Medicaid expansion. A number of governors almost immediately announced that their states would not. On July 2, Florida Governor Rick Scott stated, “Florida will opt out of spending approximately \$1.9 billion more taxpayer dollars required to implement a massive entitlement expansion of the Medicaid program.”<sup>14</sup> Mississippi governor Phil Bryant also announced later the same month, “I will resist any effort to expand Medicaid in this state.”<sup>15</sup> Governors in Texas,

13. *Ibid.*, 5. Also see pages 46 to 48:

The legitimacy of Congress’s exercise of the spending power “thus rests on whether the State voluntarily and knowingly accepts the terms of the ‘contract.’ . . . Respecting this limitation is critical to ensuring that Spending Clause legislation does not undermine the status of the States as independent sovereigns in our federal system. That system “rests on what might at first seem a counterintuitive insight, that ‘freedom is enhanced by the creation of two governments, not one.’” . . . For this reason, “the Constitution has never been understood to confer upon Congress the ability to require the States to govern according to Congress’ instructions.” . . . Otherwise the two-government system established by the Framers would give way to a system that vests power in one central government, and individual liberty would suffer. . . . Permitting the Federal Government to force the States to implement a federal program would threaten the political accountability key to our federal system.

14. Robert Pear, “Republican Governor of Florida Says State Won’t Expand Medicaid,” *New York Times*, July 2, 2012, [http://www.nytimes.com/2012/07/03/us/politics/republican-governor-of-florida-says-state-wont-expand-medicaid.html?\\_r=0](http://www.nytimes.com/2012/07/03/us/politics/republican-governor-of-florida-says-state-wont-expand-medicaid.html?_r=0).

15. Gov. Phil Bryant, “Gov. Bryant Column: The Truths about ObamaCare in Mississippi,” July 23, 2012, <http://www.governorbryant.com/gov-bryant-column-the-truths-about-obamacare-in-mississippi/>.

Georgia, Louisiana, South Carolina, and elsewhere made comparably firm statements of opposition to Medicaid expansion.<sup>16</sup>

On the other hand, a number of states signaled their support for and intention to implement expanded Medicaid coverage. Illinois Governor Pat Quinn stated, “The state of Illinois is going forward with the president of our country, President Barack Obama, to expand using Medicaid (to) those that would be covered under the Affordable Care Act.”<sup>17</sup> Governors in Delaware, Hawaii, Maryland, Massachusetts, Rhode Island, Vermont, and elsewhere expressed their enthusiasm for the Supreme Court ruling and their intentions to implement the coverage expansion of the ACA.<sup>18</sup> States including California, Connecticut, Minnesota, New Jersey, and Washington all undertook Medicaid eligibility expansions in advance of the ACA’s 2014 deadline.<sup>19</sup>

Altogether, as of November 8, 2012, a survey of the states by the Advisory Board Company found that six states had announced they were not participating in the Medicaid expansion, five were leaning against participation, two were leaning in favor, twelve (plus the District of Columbia) were participating, and twenty-five had yet to firmly declare their intentions.<sup>20</sup>

Even as these statements were being made, many ACA supporters suggested that announcements of opposition to the Medicaid expansion should be discounted as primarily reflecting political posturing, arguing that the deal being offered to states was “too good to refuse.”<sup>21</sup> Some of these advocates further argued that the Republican-governed states whose elected officials were objecting most strenuously to the coverage expansion were the same states that most stood to benefit from it, and that hospitals within these states would successfully lobby for the expansion so as to cut down on the expense of treating the uninsured.<sup>22</sup>

16. The Advisory Board Company, “Where Each State Stands on ACA’s Medicaid Expansion,” <http://www.advisory.com/Daily-Briefing/2012/07/05/Where-each-state-stands-of-the-Medicaid-expansion>.
17. Andrew Thomason, “Governor Says State Going Forward with Expanding Medicaid,” *Rock River Times*, July 4–10, 2012, <http://rockrivertimes.com/2012/07/03/governor-says-state-going-forward-with-expanding-medicaid/>.
18. Advisory Board, “Where Each State Stands.”
19. Office of Governor Mark Dayton, “Minnesota Receives Federal Approval for Medical Assistance Expansion,” news release, February 17, 2011, <http://mn.gov/governor/newsroom/pressreleasedetail.jsp?id=9826>. See also Kaiser Commission, “Federal Core Requirements.”
20. Advisory Board, “Where Each State Stands.”
21. Ezra Klein, “The Affordable Care Act’s Big Giveaway to Stingy Red States,” *Wonkblog (Washington Post)*, July 3, 2012, <http://www.washingtonpost.com/blogs/ezra-klein/wp/2012/07/03/the-affordable-care-acts-giveaway-to-stingy-red-states/>. Also see Josh Barro, “States Will Not Turn Down Obamacare’s Medicaid Expansion,” July 24, 2012, <http://www.bloomberg.com/news/2012-07-24/states-will-not-turn-down-obamacare-s-medicaid-expansion-really-.html>.
22. See Klein, “Big Giveaway,” and Kaiser Commission, “Medicaid Coverage and Spending in Health Reform,” May 2010, <http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf>. See also “Hospitals Urge Medicaid Expansion,” *Wall Street Journal*, June 29, 2012, <http://online.wsj.com/article/SB10001424052702304830704577497123131684982.html>.

These analysts' assumption that all states shared the goal of maximizing health insurance coverage within their borders even if it added to state budget expenditures, combined with the observation that the FMAP percentages in the ACA were significantly more generous than those all states had previously accepted voluntarily, led them to conclude that all states eventually will find the ACA's Medicaid expansion irresistible. Other analysts, while recognizing that increased costs were a legitimate reason for a state to potentially decline the expansion, also attributed some of the stated opposition to "ideological objections" and "political views" beyond the substantive merits of the expansion decision itself.<sup>23</sup>

Still other analysts, however, noted a variety of substantive reasons why states might not wish to expand Medicaid. Keith Hennessey, former director of the National Economic Council, observed that even a generous federal match would allow cash-strapped states' costs to increase upon expansion, noting also the risk that expansion would come with "creeping federal requirements" as well as the near-certainty that additional costs would materialize as some previously eligible (but yet uncovered) individuals signed up under the less generous prior-law federal match rate. The latter phenomenon is known as the "woodwork effect."<sup>24</sup> *Forbes* columnist Avik Roy went so far as to conclude that "states have a huge fiscal incentive to opt out" of the Medicaid expansion (also citing, among other similar concerns, this woodwork effect).<sup>25</sup>

In analyzing the states' incentives, a critical variable is whether expansion to 138 percent of the FPL constitutes an all-or-nothing decision. Can states choose only to expand for a subset of this population, or must they cover the entire population specified in the ACA to receive its generous match rate for newly eligible individuals? Were a partial expansion permissible, states could potentially limit their own costs while still significantly expanding insurance coverage.

In a later section of this paper, I will review the relevant portions of the statute as well as a recent HHS announcement that bears upon the question of partial expansion. Before that fuller analysis, it is worth noting as background that many states almost immediately sought to determine whether expansion could be partial or must be all-or-nothing. On July 2, 2012, a letter from the National Governors Association (NGA) to HHS Secretary Kathleen Sebelius asked, "Will states that expand Medicaid coverage up to a level below 133 percent of the federal poverty limit (FPL), for example up to 100 percent FPL, still receive the enhanced federal

23. Rob Lazerow, "How Did the Supreme Court's Decision on the ACA Impact Hospitals and Health Systems?" The Advisory Board Company, <http://www.advisory.com/-/media/Advisory-com/Research/H CAB/Events/Webconference/2012/The-Final-Ruling-070212.pdf>.

24. Keith Hennessey, "Why Not Expand Medicaid?" July 16, 2012, <http://keithhennessey.com/2012/07/16/why-not-expand-medicaid/>.

25. Avik Roy, "Why States Have a Huge Fiscal Incentive to Opt Out of Obamacare's Medicaid Expansion," *Forbes*, July 13, 2012, <http://www.forbes.com/sites/aroy/2012/07/13/why-states-have-a-huge-fiscal-incentive-to-opt-out-of-obamacares-medicaid-expansion/>.

medical assistance percentage (FMAP) available for ‘newly covered’ populations?”<sup>26</sup> As I will explain later, the letter’s example of 100 percent of the FPL was not chosen arbitrarily; it is an especially important income threshold given other provisions of the ACA, in particular the federal subsidies it provides for newly established health insurance exchanges.

Secretary Sebelius’s initial reply to the governors did not provide a definitive answer to the partial-expansion question, though it did state that “the federal government will completely pay for coverage under the eligibility expansion in 2014–16 and for at least 90 percent of such costs thereafter” and that “states have the flexibility to design the package for the individuals covered.”<sup>27</sup> After the Supreme Court decision, the CBO modified its earlier projection that all states would voluntarily participate in the full Medicaid expansion envisioned in the ACA. The CBO’s earlier estimate that 17 million individuals would gain Medicaid coverage by 2022 under the expansion was reduced by 6 million, to 11 million.<sup>28</sup> At the time the CBO conducted this analysis, it noted that “final regulatory guidance is not yet available regarding whether states will be allowed . . . to expand eligibility to a threshold below 138 percent of the FPL.”<sup>29</sup>

In projecting the effects of the Supreme Court decision, the CBO did not attempt a state-by-state analysis of Medicaid expansion decisions. Instead, the CBO estimated the shares of the total newly eligible population residing in states that would make different participation decisions. While recognizing the substantial financial inducements the ACA created for states to participate in the Medicaid expansion, the CBO went on record as disagreeing with those who had argued that expansion was such a trivial decision that no states would decline to implement it. The CBO’s analysis cited some of the phenomena mentioned by Hennessey and by Roy:

At the same time, there are significant disincentives for states to expand Medicaid eligibility. One is that states would ultimately have to bear some costs for an expansion of Medicaid coverage during a period when their budgets are already under pressure, in part from the rising costs of the existing Medicaid program. Health care costs tend to rise faster than those for other services or products in the economy. And although the 10 percent share of the costs of newly eligible people that states would ultimately bear would be

26. Letter from the National Governors’ Association to HHS Secretary Kathleen Sebelius, July 2, 2012, <http://www.nga.org/cms/home/federal-relations/nga-letters/executive-committee-letters/col2-content/main-content-list/july-2-2012-letter---affordable.html>.

27. Letter from Secretary Kathleen Sebelius to governors, July 10, 2012, <http://www.ncsl.org/documents/health/GovLetter7-10.pdf>.

28. *Ibid.*

29. CBO, “Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision,” July 2012.

a small share of total additional Medicaid spending, it would nevertheless represent a large extra cost for some states. In addition, CBO estimates, and states expect, that expanding the Medicaid-eligible population would lead to an increase in enrollment among those who would have been eligible under prior law and would not qualify for the higher federal matching rates, resulting in additional costs for participating states. States may also fear that the federal government, which faces its own severe budgetary pressures, will ultimately reduce the federal matching rate and that if it did so, rolling back expansions already in place would be difficult.<sup>30</sup>

As will be detailed more fully later in this paper, in the wake of the Supreme Court ruling, states have a powerful incentive, if they expand Medicaid coverage at all, to expand to something less than the 138 percent of the FPL specified in the ACA—specifically, to 100 percent of the FPL. Recognizing this phenomenon, the CBO modified its earlier projections of universal participation by the states:

CBO anticipates that, instead of choosing to expand Medicaid eligibility fully to 138 percent of the FPL or to continue the status quo, many states will try to work out arrangements with the Department of Health and Human Services (HHS) to undertake partial expansions. For example, some states will probably seek to implement a partial expansion of Medicaid eligibility to 100 percent of the FPL, because, under the ACA, people below that threshold will not be eligible for subsidies in the insurance exchanges while people above that threshold will be if they do not have an offer of affordable coverage from an employer and meet other eligibility requirements.<sup>31</sup>

Specifically, the CBO's updated projections reflected the following estimates:

- 33 percent of the potential newly eligible population would be in states that would fully expand Medicaid up to 138 percent of the FPL.
- 40 percent of the potential newly eligible population would be in states that would partially expand Medicaid up to 100 percent of the FPL.
- 10 percent of the potential newly eligible population would be in states that

30. Ibid.

31. Ibid. The CBO's June 2012 analysis appears to be predicated on the assumption that states undertaking a partial expansion will receive the ACA's enhanced FMAP rate for new Medicaid eligibles; HHS subsequently issued conflicting guidance discussed later in this paper. The more recent announcement may reduce state incentives to expand Medicaid coverage for childless adults with incomes below 100 percent of the FPL.

would partially expand Medicaid only up to an unspecified percentage below the FPL.

- 17 percent of the potential newly eligible population would be in states that would not expand Medicaid at all.

As mentioned, the CBO lowered its overall estimates for long-term Medicaid coverage by 6 million relative to its projections prior to the Supreme Court decision. Of these, 3 million would be insured under the ACA's newly established exchanges, with the other 3 million remaining uninsured. The CBO also projected that this partial expansion would reduce the woodwork effect of enrollment by previously eligible individuals by roughly one-fifth relative to its earlier projections.

In addition to revising its expectation to only partial participation, the CBO projected that such expansions as would occur would be somewhat delayed as states were no longer bound by the ACA's timeline: instead of occurring by 2014 as originally required by the ACA, one-third would occur in 2014, one-third in 2015, and one-third in 2016 or later.<sup>32</sup>

It should be noted that the CBO and the states must look at the ACA through different lenses. Though the CBO notes that state expansion decisions may be affected by expectations that the federal government might reduce future support for Medicaid relative to current law projections, the CBO cannot directly reflect such hypothetical changes because its scorekeeping task is to model the effects of current law alone. Planners of state budgets, however, must factor in the extent to which they believe future federal financing may deviate from the current-law path. As will be detailed in a later section of this paper, there are several reasons why it is quite unlikely that future federal Medicaid expenditures will conform to those scheduled under current law.

In sum, states now face a decision that is anything but trivial: whether to expand Medicaid. Evidence for the complexity of the decision is convincingly diverse. There are the vastly different statements made by elected officials, reflecting different circumstances and value judgments. There are financial considerations that weigh against expansion as there are considerations that weigh in favor of it. Also in evidence are the analytical opinions of nonpartisan scorekeepers, who currently project that states will choose a variety of divergent paths in the wake of the Supreme Court decision.

The following section of this study will describe critical factors bearing upon the decisions facing state governments, factors that range from reasonable expectations of future federal financing support to the statutory language of the ACA itself.

32. Ibid.

## V. EXPANDING MEDICAID: WEIGHING CONFLICTING VALUE JUDGMENTS

THE DECISION WHETHER to expand Medicaid becomes trivial for states only if it is assumed that one value trumps all others. If the value of expanding health insurance coverage for the uninsured trumps all considerations pertaining to state budgetary pressures, the decision in favor of expansion is trivial. If concerns about state budgetary pressures trump all others, then the decision against expansion is trivial. Advocates who argue that all states must unanimously arrive at a similar conclusion are implicitly assuming that only one of these value judgments matters.

In the real world, however, state governors must balance the competing values of, on the one hand, maximizing externally financed health benefits for their citizens and, on the other, constraining the growth of state budget expenditures. Each governor faces incentives to maximize the health benefits his own state's citizens receive that are financed by entities outside the state, while also minimizing his state's budgetary exposure. Each governor thus faces a value weighting problem that can be depicted like this:



Clearly it is theoretically possible for different states to arrive at different policy conclusions depending on how they respectively weigh these competing considerations. But beyond hypotheticals, the empirical evidence shows that different states *do* weigh these competing values differently.

We know that all states attach a significant value to providing health insurance coverage for Medicaid's historical mandatory coverage population, as evidenced by the fact that all states voluntarily participate in Medicaid despite substantial state expenditures resulting from that decision.<sup>33</sup> At the same time, we know that most

33. Even this participation should not be interpreted as necessarily meaning that all states would decide today, if they could make the decisions again from scratch, to insure their entire currently covered population under current-law Medicaid FMAP rates if doing so added to their existing budget costs. States now face substantially higher Medicaid costs than when previous Medicaid participation decisions were made; states' ongoing coverage levels likely reflect to a certain extent the unattractiveness of taking away coverage from individuals already receiving it. This legacy commitment of future state dollars for the benefit of existing coverage populations is a factor rendering it more difficult for states to find additional money to finance a further coverage expansion.

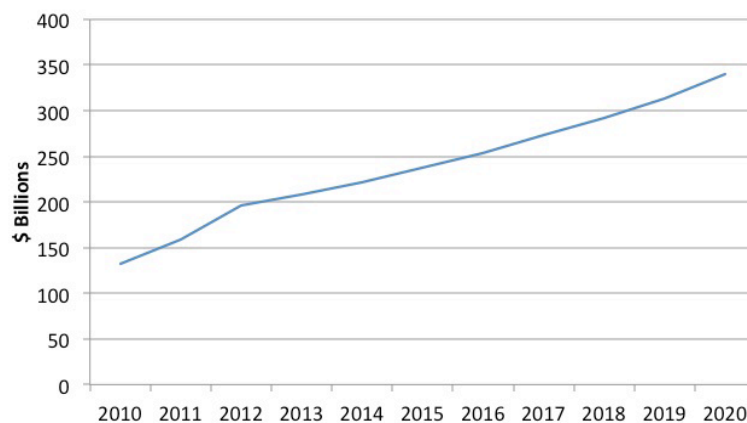


states do *not* value expanding coverage to others over and above all cost considerations. We know this because relatively few states have taken maximal advantage of pre-ACA opportunities to expand Medicaid to cover populations generally similar to the intended beneficiaries of the ACA’s Medicaid expansion. Specifically, even the so-called “expansion states” that had gone beyond Medicaid’s previous minimum coverage requirements had not (with the exceptions of Massachusetts and Vermont) chosen to cover all childless adults with incomes up to 133 percent of the FPL; the vast majority of states left most such individuals uncovered by Medicaid.<sup>34</sup>

By itself, the federal government potentially financing the majority of associated costs has historically been an insufficient inducement for all states to seek waivers to provide Medicaid coverage to the ACA’s intended beneficiary population. An important question is how the provisions of the ACA, taken together, change this calculus.

In answering this question, the primary consideration competing with the benefits of expanded coverage—that is, increased state Medicaid expenditures—will take on greater importance in the near future. With or without participating in the ACA’s coverage expansion, state Medicaid expenditures are projected to grow dramatically in the upcoming years.<sup>35</sup> Figure 1 shows the increase in state Medicaid expenditures projected by the Centers for Medicare & Medicaid Services (CMS) prior to the Supreme Court decision, when it was still assumed that the coverage expansion would be compulsory:

**FIGURE 1. PROJECTED STATE MEDICAID EXPENDITURES (UNIVERSAL PARTICIPATION ASSUMED)**

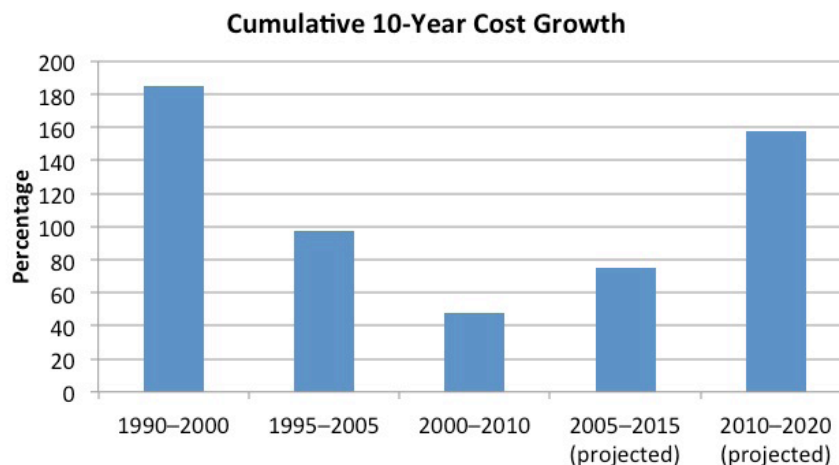


Source: CMS, “2011 Actuarial Report on the Financial Outlook for Medicaid,” <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/MedicaidReport2011.pdf>.

34. Kaiser Commission, “Medicaid Coverage and Spending in Health Care Reform.”
35. Throughout this paper, the phrase “state Medicaid expenditures” refers to Medicaid expenditures that are financed by the state as opposed to total Medicaid expenditures, the majority of which are financed by the federal government.

Even by the standard of high historical Medicaid cost growth, this projected increase of 158 percent cumulatively over 10 years would be an extremely rapid rate of state expenditure increases, despite the generous FMAP rate promised under the ACA. These state Medicaid cost growth rates would be a dramatic acceleration relative to recent years, as shown in figure 2.

FIGURE 2. STATE MEDICAID EXPENDITURE PERCENTAGE GROWTH (UNIVERSAL PARTICIPATION ASSUMED)



Source: CMS, "2011 Actuarial Report."

Note: The graph displays overlapping 10-year periods to avoid distortions in apparent trends arising from any one particular year or period. For example, states received increased federal Medicaid financing assistance during 2009 to 2011 as a result of stimulus legislation. As a result, comparing only the 2000 to 2010 and 2010 to 2020 periods could be seen as understating cost growth in the former period and overstating it in the latter period. Overlapping 10-year periods are shown to prevent any particular endpoint years from obscuring long-term trends.

The rising pressure that Medicaid will place on state budgets going forward is only partially captured by describing cost growth in terms of percentage rates. Future cost growth will be added to expenditures that rise from a much higher base relative to earlier years due to historical cost growth. In 1990, total state Medicaid expenditures were approximately \$31 billion, as compared with costs that had risen to over \$150 billion by 2008 (though reduced in subsequent years by the increased federal assistance to states provided by the 2009 stimulus law).<sup>36</sup>

There is a general consensus that Medicaid costs are already straining state budgets even before considering the cost of covering additional populations under the ACA. A bipartisan State Budget Crisis Task Force reported in July 2012 that "Medicaid spending growth is crowding out other needs."<sup>37</sup> A number of states

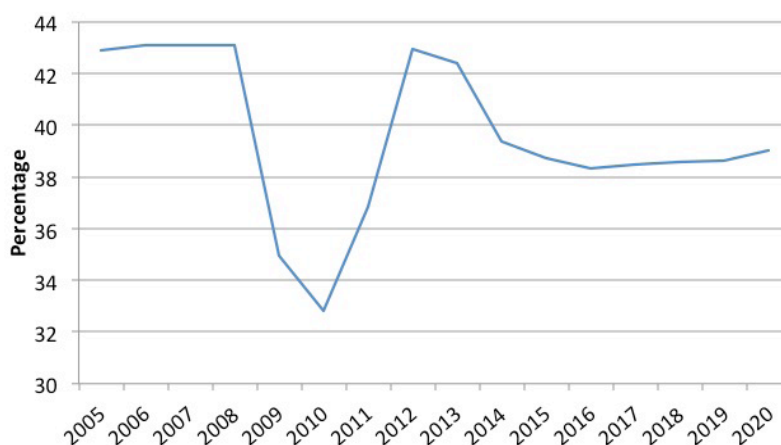
36. CMS, "2011 Actuarial Report."

37. State Budget Crisis Task Force, "Report of the State Budget Crisis Task Force," July 2012, <http://www.statebudgetcrisis.org/wp-content/images/Report-of-the-State-Budget-Crisis-Task-Force-Full.pdf>.

continue to wrestle with current and projected budget shortfalls that were caused or exacerbated by the recent recession.<sup>38</sup> The National Association of State Budget Officers reports that in 2011, Medicaid amounted to nearly 24 percent of state budget expenditures despite the temporary FMAP increase provided under the 2009 stimulus law.<sup>39</sup>

A further important factor is that not only are total Medicaid costs projected to increase markedly in the upcoming years, but states must also budget to finance a much higher *percentage* of such costs than they faced from 2009 to 2011. For most of recent history, federal support for Medicaid has averaged 57 percent of its total expenditures, with states carrying the other 43 percent. However, the states were responsible for a lower share of financing in 2009–11 (35 percent in 2009, 33 percent in 2010, and 37 percent in 2011), when federal stimulus assistance peaked. If states participate in the ACA’s full Medicaid expansion, the long-term share of federal support is projected to be 61 percent, with states picking up the other 39 percent, assuming that the federal government does not retreat from the ACA’s generous FMAP rates. States thus already face the substantial challenge of budgeting for the expiration of temporary stimulus assistance even before taking on additional coverage responsibilities, as figure 3 shows.

FIGURE 3. STATE SHARE OF TOTAL MEDICAID EXPENSES



Source: CMS, "2011 Actuarial Report."

38. Phil Oliff, Chris Mai, and Vincent Palacios, "States Continue to Feel Recession's Impact," Center on Budget and Policy Priorities, updated June 27, 2012, <http://www.cbpp.org/cms/index.cfm?fa=view&id=711>.
39. National Association of State Budget Officers (NASBO), Budget Topics: Healthcare and Medicaid, <http://www.nasbo.org/budget-topics/healthcare-medicaid>. See also NASBO, "2010 State Expenditure Report," <http://www.nasbo.org/sites/default/files/2010%20State%20Expenditure%20Report.pdf>.

States will face most of these rising cost shares whether or not they choose to expand under the terms of the ACA. The CMS projected that the coverage provisions of the ACA, if universally implemented, would add roughly \$64 billion to state Medicaid costs through 2020, or roughly 3 percent of total state Medicaid expenditures during that span. The increase might be as much as \$85 billion under the assumptions guiding the CBO's March 2012 estimates, or roughly 4 percent of total expenditures through 2020.<sup>40</sup> Either percentage would be small relative to the accompanying increase in federal costs and also relative to states' total projected Medicaid budgets. But it would be an incremental push in the wrong fiscal direction at a time when many states have been struggling to lower Medicaid expenditures rather than increase them.<sup>41</sup>

## VI. INCENTIVES FOR STATES TO LIMIT MEDICAID COVERAGE TO 100 PERCENT OF THE FEDERAL POVERTY LEVEL

WHILE MANY OF the incentives affecting state coverage expansion decisions are complex and conflicting, all states appear to face one common incentive. The interaction of various provisions of the ACA, in combination with the 2012 Supreme Court decision, now renders it unattractive for states to expand Medicaid to cover childless adults with incomes above 100 percent of the FPL. For the population with incomes above this level, there is a straightforward confluence of state interests; states can minimize their budgetary exposure by declining to cover this population under Medicaid, while at the same time providing these individuals access to potentially more generous health insurance coverage.

The ACA provides for the establishment of exchanges through which low-income individuals may purchase health insurance and creates substantial federal subsidies for those who do so. These subsidies are only available to individuals with incomes between 100 percent and 400 percent of the FPL who are not eligible for

40. In CMS, "2011 Actuarial Report," the CMS projected that federal costs would grow by \$500 billion due to the expansion through 2020, in comparison with a CBO estimate of \$522 billion in Douglas W. Elmendorf, "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010," congressional testimony, March 30, 2011, before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12119/03-30-healthcarelegislation.pdf>. By early 2012, changed economic assumptions had caused the CBO to conclude that the cost of the Medicaid expansion would be greater: \$668 billion through 2020. See CBO, "Updated Estimates."

41. In "Federal Core Requirements and State Options in Medicaid," the Kaiser Commission writes, "However, other states are seeking authority to reduce eligibility to address state budget shortfalls. Through 2010 and into 2011, states held steady or made targeted improvements in their eligibility and enrollment rules, largely due to the temporary Medicaid fiscal relief and the MOE [maintenance of effort] requirement. However, states continue to face budget shortfalls, due to recession-driven enrollment growth, the end of fiscal relief on June 30, 2011, and state revenues that remain depressed, and some states have been calling for the authority to reduce eligibility and impose more restrictive enrollment policies."

Medicaid.<sup>42</sup> The subsidies include tax credits that limit the premiums paid by those between 100 percent and 133 percent of the FPL to no more than 2 percent of their household incomes, with higher limits for higher income ranges.<sup>43</sup>

If states cover adults with incomes above 100 percent of the FPL under Medicaid, per the terms of the ACA states will face 10 percent of the associated costs by 2020. If instead these individuals remain uninsured by Medicaid and receive their health insurance through the ACA's exchanges, states will pick up none of the costs, as the subsidy for these individuals would be provided through federal income tax credits.<sup>44</sup> States thus could potentially eliminate their own costs of covering this population if they leave them uninsured by Medicaid and their coverage is subsidized solely by the federal government.<sup>45</sup>

Not only would declining to cover those over 100 percent of the FPL through Medicaid limit states' direct costs, but the available analysis suggests that if these individuals are covered through the exchanges, it could also improve the quality of the health insurance coverage they receive. The CBO has calculated that the monetary value of the federal subsidy per individual exchange participant in this income range would be approximately \$9,000 annually by 2022, whereas the federal

42. In "Estimates for the Insurance Coverage Provisions of the Affordable Care Act," the CBO writes, "To be eligible for subsidies, individuals and families must have income between 100 percent and 400 percent of the FPL and cannot have access to an affordable offer of insurance from an employer or be eligible for Medicaid (among other criteria)." Also see January Angeles, "How Health Reform's Medicaid Expansion Will Impact State Budgets," Center on Budget and Policy Priorities, July 25, 2012, <http://www.cbpp.org/cms/?fa=view&id=3801>.
43. Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1001 (2010). Note that the 5 percent income exclusion does not apply to the exchange subsidies, so those with income of 138 percent of the FPL would face slightly higher premiums. The law also provides for subsidies that limit beneficiary cost-sharing.
44. These "costs" are the government subsidy costs; depending on how such exchanges are established and who administers them, states could face administrative and IT costs.
45. There is an ongoing controversy over whether the federal subsidies can be operative if the states decline to establish the exchanges and leave their administration for the federal government. Legal scholars Michael Cannon and Jonathan Adler have argued that the language of the ACA prohibits federal subsidies from operating unless the states themselves establish the exchanges. See Michael Cannon and Jonathan Adler, "The Illegal IRS Rule to Increase Taxes and Spending under ObamaCare," testimony before the US House of Representatives Committee on Oversight and Reform, <http://www.cato.org/publications/congressional-testimony/illegal-irs-rule-increase-taxes-spending-under-obamacare-1>. The IRS has taken the opposite view: see "Health Insurance Premium Tax Credit," notice of proposed rulemaking and notice of public hearing, 76 Fed. Reg. No. 159 (August 17, 2011), <http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20728.pdf>, which has been independently argued for by Judith Solomon, "Health Reform Law Makes Clear That Subsidies Will Be Available in States with Federally Operated Exchanges," Center on Budget and Policy Priorities, July 16, 2012, <http://www.cbpp.org/cms/index.cfm?fa=view&id=3803>. Regardless of who must set up the exchanges, the states have a substantial financial incentive for the federal subsidies to be triggered if they intend for those with incomes over 100 percent of the FPL to be insured. There is also the possibility that some of these eligible individuals will choose to remain uninsured rather than to participate in the exchanges. As later explained, state costs for the uninsured are generally substantially less than if they are covered under Medicaid.

cost of covering them under Medicaid would be \$6,000—and thus, including all contributions, the total value of their Medicaid coverage would still be less than \$7,000.<sup>46</sup>

It is quite likely that individuals covered through the exchanges will receive higher-quality health care services than they would through Medicaid. The quality of health services in Medicaid is often fiercely debated, but one factor interfering with access to care under the program is the number of providers unwilling to accept its comparatively low provider reimbursement rates, a dynamic that beneficiaries would be spared by participating instead in the more generously subsidized exchanges.<sup>47</sup>

States, then, have a substantial incentive to see that their citizens with incomes above 100 percent of the FPL receive services through federally subsidized exchanges rather than through Medicaid. Importantly, this incentive is the same for states wherein Medicaid programs already cover childless adults up to 133 percent of the FPL as for those that do not yet do so. States such as Massachusetts and Vermont could potentially strengthen their budget situations and improve their citizens' health outcomes simultaneously by scaling back Medicaid coverage once the new exchanges are in place.

Presumably to prevent such Medicaid rollbacks, the ACA contains a “maintenance of effort” provision to prohibit states from tightening their previous Medicaid eligibility requirements. It only lasts, however, until the new exchanges are satisfactorily operational:

During the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on the date

46. CBO, “Estimates for the Insurance Coverage Provisions of the Affordable Care Act.” The CBO estimates that the share of the premiums faced by these individuals would be in the hundreds of dollars annually, with a total insurance value in the area of \$9,500 annually. The CBO also estimates that families who participate in the exchanges with incomes at or below 150 percent of the FPL would, after cost-sharing subsidies are taken into account, have 94 percent of their covered medical expenses paid by their insurance coverage. Medicaid premiums and cost-sharing amounts would likely be less than in the exchanges, but the value of the Medicaid insurance coverage would also be substantially less. CMS estimates are consistent with these figures. CMS, “2011 Actuarial Report.” “Value,” of course, is an inherently subjective concept incorporating many individual-specific considerations; the term is used here to refer to the equivalent monetary value. In both Medicaid and the health exchanges, the federal subsidy cost is somewhat less than the total insurance value (in 2022, the year estimated by CBO) because the federal government pays for less than 100 percent of the cost of the insurance.
47. Some critics go so far as to label Medicaid “America’s worst health care program.” Avik Roy, “Medicaid: America’s Worst Health Care Program,” *National Review*, August 6, 2012, <http://www.nationalreview.com/articles/313120/medicaid-america-s-worst-health-care-program-avik-roy>. Jonathan Cohn argued the opposite case in “The Conservative Assault on Medicaid,” *New Republic* (blog), March 10, 2011, <http://www.tnr.com/blog/jonathan-cohn/85054/conservative-attack-medic-aid-health-reform>, but agreed that “to be clear, Gottlieb, Roy, and the rest are absolutely correct when they suggest Medicaid has problems. For certain populations and particularly in certain states, it’s unambiguously inferior to private insurance and to Medicare. Partly that reflects structural problems in the program, like poor management of chronic disease. But partly (perhaps mostly) it reflects the fact that Medicaid reimburses the providers of medical care at absurdly low rates. This makes it harder for Medicaid patients to find professionals that will see them.”

on which the Secretary determines that an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act is fully operational, as a condition for receiving any Federal payments under section 1903(a) for calendar quarters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.<sup>48</sup>

The original idea with the ACA was that this provision would prevent states from tightening Medicaid eligibility requirements just before the exchanges were established, and then moving part of their previously Medicaid-eligible population onto them. The ACA's mandatory Medicaid expansion and new health exchanges were supposed to work together. Simultaneously with the first operation of the exchanges, the states would be required to cover those up to 138 percent of the FPL under Medicaid, largely keeping this population off the exchange rolls.

After the Supreme Court ruling, however, the federal government can no longer enforce the ACA's new mandatory Medicaid coverage standard, leaving states free to take maximum advantage of the new exchange subsidies at the time that the law's Maintenance of Effort provision expires.

The CBO sees these incentives similarly:

If a state decides not to expand its Medicaid program to the extent authorized under the ACA, some people who would not be eligible for Medicaid will instead be eligible for premium and cost-sharing subsidies in the insurance exchanges. In particular, individuals with income between 100 percent and 138 percent of the FPL who live in a state that chooses not to expand Medicaid coverage or to defer such an expansion and who meet certain other criteria would be eligible for such subsidies.<sup>49</sup>

The CBO later elaborated:

CBO anticipates that, instead of choosing to expand Medicaid eligibility fully to 138 percent of the FPL or to continue the status quo,

48. See the text of the Social Security Act as amended by the ACA in Social Security Act, "State Plans for Medical Assistance."

49. CBO, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act."

many states will try to work out arrangements with the Department of Health and Human Services (HHS) to undertake partial expansions. For example, some states will probably seek to implement a partial expansion of Medicaid eligibility to 100 percent of the FPL, because, under the ACA, people below that threshold will not be eligible for subsidies in the insurance exchanges while people above that threshold will be if they do not have an offer of affordable coverage from an employer and meet other eligibility requirements.<sup>50</sup>

As previously mentioned, the CBO projected after the Supreme Court ruling that 40 percent of the ACA's potential newly Medicaid-eligible population reside in states that will choose to expand Medicaid only up to 100 percent of the FPL; the CBO did not publish the potential costs of other states limiting their expansions or rolling back previous coverage, both of which would be expected to add considerably to the federal costs of maintaining the exchanges.

Former CBO director Douglas Holtz-Eakin has publicly noted the states' new incentive to shift part of their Medicaid population to the exchanges. This potential outcome is described by some of the ACA's advocates as a "terrifying scenario" of Medicaid coverage reduction.<sup>51</sup>

One way to mitigate these incentives would be to scale back the subsidies provided to individual participants in the ACA's exchanges. Reducing the subsidies by roughly one-quarter or more would render their value to participants comparable to the benefits they would expect to receive under Medicaid. This reduction would roughly equalize considerations from the beneficiary's perspective, although the states would still face higher costs under the Medicaid coverage option. An alternative would be to limit federal exchange subsidies only to those with incomes above 138 percent of the FPL, leaving Medicaid as the sole federally subsidized option for states to cover this portion of their populations. In any event, reducing the projected costs of the ACA's exchange subsidies is important both to reduce the projected costs of the ACA as a whole and to mitigate incentives for states to have the federal

50. Since the CBO published this paragraph, HHS has issued guidance indicating that the federal government will not provide the ACA's enhanced FMAP rate for partial state expansions. However, this guidance does not eliminate states' incentives to have the federal government assume the cost of covering those with incomes above 100 percent of the FPL through the exchanges.

51. Phil Galewitz, "Supreme Court Ruling Allows States to Cut Off Medicaid to Those Now Enrolled," *Kaiser Health News*, July 3, 2012, <http://www.mcclatchydc.com/2012/07/03/154943/supreme-court-health-care-ruling.html>; David Dayen, "States Opting Out of Medicaid Expansion Could Reduce Their Rolls without Consequences," *FDL*, July 5, 2012, <http://news.firedoglake.com/2012/07/05/states-opting-out-of-medicaid-expansion-could-reduce-their-rolls-without-consequences/>. Although the exchanges could potentially offer more generous coverage to individuals shifted out of Medicaid, this scenario is "terrifying" to some advocates for various reasons, including the risk that some now covered under Medicaid may simply go uninsured; the potentially higher out-of-pocket costs under the exchanges; and a philosophical preference for government-provided insurance, among other reasons.



government absorb 100 percent of the cost of expanding coverage for those with incomes greater than the FPL.<sup>52</sup>

## VII. EXPANDING MEDICAID TO COVER CHILDLESS ADULTS WITH INCOMES BELOW 100 PERCENT OF THE FPL

WHILE STATES HAVE a powerful incentive to shift to the federal government the entire cost of subsidizing insurance coverage for childless adults with incomes above 100 percent of the FPL, the situation is more complex with respect to those with incomes below the poverty level. Concerning those in poverty, states face conflicting incentives and must make important subjective value judgments.

As earlier discussed, states must weigh any positive value associated specifically with covering individuals under Medicaid against the additional costs to the state of doing so. In the past, states have made a wide variety of choices reflecting substantially different weightings of these conflicting considerations. It cannot be simplistically assumed either that the value of Medicaid coverage carries no weight, or that it trumps all other considerations.

Cost considerations facing the states can be at least roughly estimated. The CBO estimates that of those who would have been newly eligible for Medicaid coverage if all states fully participated in the ACA's coverage expansion, roughly two-thirds have incomes below 100 percent of the FPL.<sup>53</sup> Actual proportions would vary significantly from state to state, but on average if states expanded coverage up to only 100 percent of the FPL, their Medicaid costs would increase by roughly 2 to 3 percent relative to prior law under the CBO's 2012 assumptions and providing that the high federal support levels in the ACA are maintained.<sup>54</sup> It is, however, important to remember that even this 2 to 3 percent increase would be on top of an already sharply rising Medicaid cost curve adding over 150 percent to annual state Medicaid costs within 10 years.

Some have suggested that expanding insurance coverage could actually save money for the states on balance by reducing their costs of treating the uninsured.<sup>55</sup> While a total evaluation should indeed net such savings against the gross costs of

52. Charles Blahous, "The Fiscal Consequences of the Affordable Care Act" (Mercatus Research, Arlington, VA: Mercatus Center at George Mason University, April 2012).

53. CBO, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act," 13.

54. Again, the CBO's calculations were predicated on the assumption that states successfully negotiate to receive the ACA's enhanced FMAP rate for a partial expansion. HHS's more recent announcement indicates that states will not receive the enhanced FMAP rate for a partial expansion. In view of the HHS's letter, the actual cost to states for a partial expansion could be somewhat higher than quantified here.

55. Council of Economic Advisors, "The Impact of Health Insurance Reform on State and Local Governments," September 2009, <http://www.whitehouse.gov/assets/documents/cea-statelocal-sept-15-final.pdf>; Annie Lowrey, "Could States Save by Expanding Medicaid?," *Economix* (blog), *New York Times*, July 5, 2012, <http://economix.blogs.nytimes.com/2012/07/05/could-states-save-by-expanding-medicaid/>.

expanding Medicaid coverage, it is unlikely they would fully offset the new costs. A Kaiser Foundation study found that roughly 33 percent of the medical costs of the uninsured are “uncompensated,” with the remainder financed through individual out-of-pocket payments and through insurance as some of these individuals are insured for part of the year. Most uncompensated costs were financed by the federal government, with less than one-third financed by states, resulting in state budget costs equaling roughly 10.6 percent of the uninsured population’s total medical bills.<sup>56</sup> The same report found that the uninsured received only about 55 percent of the total medical care received by the insured population and that, if covered, per-person health spending for the uninsured would increase by 39 percent. This finding suggests that current direct state costs for the uninsured equate to roughly 8 percent of the cost of covering the same population under Medicaid. Thus, in order for states to come out ahead fiscally by expanding Medicaid, the effective FMAP percentage associated with the coverage expansion would likely need to be extremely high—perhaps as high as 92 percent on average, with states financing only 8 percent.

Beginning in 2020, the ACA’s specified FMAP for the expansion population is 90 percent. Even when working first from the assumption that states ultimately receive this enhanced FMAP rate for all those newly eligible, one is led to the conclusion that state costs would increase significantly under a Medicaid expansion. Part of the reason is that one must take into account the woodwork effect of previously eligible individuals with lower FMAP match rates being signed up for the first time under the ACA’s outreach processes.<sup>57</sup> The CBO estimates that of those who would receive new Medicaid coverage under the ACA,

- approximately 25 percent would be newly eligible enrollees with incomes between 100 percent and 138 percent of the FPL;
- approximately 50 percent would be newly eligible enrollees with incomes below 100 percent of the FPL; and
- approximately 25 percent would be previously eligible enrollees who had not already enrolled.<sup>58</sup>

This distribution suggests that if states were to expand Medicaid and receive

56. Jack Hadley and John Holahan, “The Cost of Care for the Uninsured,” Kaiser Commission, May 2004, <http://www.kff.org/uninsured/upload/the-cost-of-care-for-the-uninsured-what-do-we-spend-who-pays-and-what-would-full-coverage-add-to-medical-spending.pdf>.

57. The ACA specifies that if an individual applying for an exchange is found to be eligible for Medicaid, he or she will be enrolled in that program. Patient Protection and Affordable Care Act, § 1413, 111th Cong. (2010), <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>. Irrespective of these outreach processes and state expansion decisions, it is reasonable to expect that some previously eligible individuals will enroll in Medicaid under pre-ACA FMAP rates in response to the ACA’s imposition of a tax on those without health insurance.

58. CBO, “Estimates for the Insurance Coverage Provisions of the Affordable Care Act,” 13.

the ACA's enhanced FMAP rate, then roughly two-thirds of the newly Medicaid-insured population with incomes below the FPL will be covered with a long-term FMAP rate of 90 percent, the remaining third being those previously eligible with an average FMAP rate of 57 percent. If these assumptions are accurate, states would expect to pay on average roughly 21 percent of the costs of covering this portion of the expanded population over the long term, far higher than the estimated break-even level of 8 percent.

Thus, taking important relevant factors into account, including both the higher amount of health services received by the uninsured and the woodwork effect of newly covering those previously eligible, it appears likely that expanding Medicaid coverage would add substantially to state budget costs. Again, the increase in state costs does not mean that expansion's potential cost savings to beneficiaries and hospitals should be ignored, nor does it prove that a coverage expansion should not be undertaken. It rather means that the likely costs of the expansion to states must be weighed against any positive value associated with bringing more individuals into Medicaid.

Three important caveats should be associated with these figures. First, as this paper will later explore, the figures assume that expanding Medicaid does not ultimately expose states to higher costs than those outlined specifically in the ACA, despite the severe fiscal pressures on the federal government to reduce its own rising Medicaid cost share.

Second, actual cost increases would vary from state to state. States such as Texas, Nevada, and Montana would face higher proportional cost increases due to their higher numbers of current uninsured with incomes below the FPL.<sup>59</sup> In contrast, the Kaiser Foundation projected that Massachusetts would experience net cost savings under the ACA even if it were to continue to cover adults up to 133 percent of the FPL "because the benefit of the expansion match rate for current and new coverage of childless adults outweighs any new state costs related to increases in participation for parents at the regular Medicaid match rate."<sup>60</sup>

Third, there is the important question of *whether* the states may undertake a partial expansion while still receiving the ACA's higher FMAP rate for the expansion population. Whether the ACA's enhanced FMAP rate applies to a partial expansion is a critical financial consideration for states. This is why the aforementioned letter from the NGA to HHS Secretary Sebelius asked specifically whether it would apply to expansion up to 100 percent of the FPL. If the enhanced FMAP does so apply, it is likely that several states will give strong consideration to expanding up to 100

59. See Kaiser Commission, "Medicaid Coverage and Spending in Health Reform." The Kaiser study assumes full expansion up to 133 percent of the FPL and has thus been cross-referenced with Kaiser Family Foundation, "Health Insurance Coverage of Adults 19–64 Living in Poverty (under 100% FPL), States (2010–2011), U.S. (2011)," <http://www.statehealthfacts.org/comparetable.jsp?ind=131&cat=3>, which shows current uninsured rates for those below 100 percent of the FPL.

60. Kaiser Commission, "Medicaid Coverage and Spending in Health Reform," 4.

percent of the FPL. If it does not, it stands to reason that many states will choose not to expand their current eligibility criteria, as the historical FMAP rate has been an insufficient inducement in the past.

The CBO noted in its June 2012 analysis that “final regulatory guidance is not yet available regarding whether states will be allowed . . . to expand eligibility to a threshold below 138 percent of the FPL.” The CBO nevertheless assumed that states would be allowed to undertake a partial expansion financed with the new, higher FMAP.<sup>61</sup> Indeed, the CBO projected that 40 percent of the potential newly Medicaid-eligible population would be in states that made this choice—an amount higher than those in states making any other specific choice.

How state finances would be affected by a partial expansion is a function of both the ACA’s text and discretionary policy decisions made by the federal government. The ACA modified Medicaid law to include all childless adults with incomes below 133 percent of FPL (effectively 138 percent) among the mandated coverage population.<sup>62</sup> Longstanding law permits the HHS secretary to “make no further payments” to a state whose plan “no longer complies” with Medicaid’s mandatory eligibility criteria.<sup>63</sup> The 2012 Supreme Court decision prohibits the federal government, however, from withholding “existing Medicaid funds” for states that do not comply specifically with the ACA expansion.<sup>64</sup> The court did not directly address the question of what FMAP would apply if a state sought to cover only a subset of the ACA’s expanded mandatory coverage population.

The text of the ACA specifies that its enhanced FMAP rates (100 percent for 2014–16, phasing down to 90 percent in 2020 and beyond) apply to “newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i)” —this being the subclause that describes childless adults with incomes below 133 percent of the poverty line (effectively 138 percent due to the 5 percent income exclusion).<sup>65</sup>

Another section of the law defines “newly eligible” as anyone described in that subclause who was not eligible for Medicaid when the ACA was enacted.<sup>66</sup> The language appears to apply the enhanced FMAP rate to a newly eligible person at 100 percent of the FPL regardless of how someone else (for example, a person at 125 percent of the FPL who is denied eligibility) is treated. An individual at 100 percent of the FPL is by definition also below 133 percent of the FPL and thus is, if not previously eligible, to be covered with the enhanced FMAP rate.

The totality of the statutory language when combined with the Supreme Court ruling establishes negotiating leverage both for the federal government and for

61. CBO, “Estimates for the Insurance Coverage Provisions of the Affordable Care Act.”

62. Social Security Act, “State Plans for Medical Assistance.”

63. Social Security Act, “Operation of State Plans.”

64. Supreme Court, *National Federation*.

65. Sections 1905 and 1902 of the Social Security Act, [http://ssa.gov/OP\\_Home/ssact/title19/1905.htm](http://ssa.gov/OP_Home/ssact/title19/1905.htm) and [http://ssa.gov/OP\\_Home/ssact/title19/1902.htm](http://ssa.gov/OP_Home/ssact/title19/1902.htm).

66. Section 1905 of the Social Security Act, [http://ssa.gov/OP\\_Home/ssact/title19/1905.htm](http://ssa.gov/OP_Home/ssact/title19/1905.htm).

the states. However, it leaves the states with ultimate control over the expansion decision, and substantial leverage accompanies that state control. The states cannot be compelled to expand fully to 133 percent (138 percent) of the FPL, while the enhanced FMAP rate appears to apply to newly covered childless adults with incomes below that level. On the other hand, the federal HHS secretary is empowered to make an up-or-down determination of whether the state is in compliance with federal Medicaid eligibility standards, and to withhold new funding—though not existing funding—if a negative determination is made.<sup>67</sup>

Clearly, a state cannot be said to be in direct compliance with Medicaid’s mandatory eligibility criteria (set forth by the ACA in section 1902 of the Social Security Act) if it fails to cover all those up to 133 percent of the FPL. But other sections of Medicaid law permit the HHS secretary to waive such stipulations. For example, section 1115 permits the HHS secretary to waive section 1902 if he or she believes doing so is “likely to assist in promoting the objectives” of Medicaid.<sup>68</sup> Notably, section 1115 allows for waivers of 1902 (eligibility criteria) but does not mention waiving 1905 (setting forth the FMAP rates).

In December 2012, HHS Secretary Sebelius wrote to governors to indicate that the ACA’s enhanced FMAP rate would not apply to a Medicaid expansion that is less than that envisioned under the ACA. The letter stated that waivers for partial expansions would be considered only “at the regular matching rate.”<sup>69</sup> This announcement is likely to considerably reduce state incentives to expand Medicaid even to 100 percent of the FPL.

Ultimately, state coverage levels may well be a function of whether states can negotiate mutually satisfactory terms with the federal government for a section 1115 waiver allowing for coverage only up to 100 percent of the FPL or to a lower-income level. There are at least three critical factors that point to this potential outcome: first, the federal government cannot compel the states to expand at all; second, the states have strong disincentives to expand beyond 100 percent of the FPL; and third, the historical FMAP rates HHS has recently announced as the only available ones have by themselves been an insufficient inducement for most states to seek waivers to cover childless adults in these income ranges.

It is therefore likely that many states will decline to undertake even a partial

67. The court’s ruling was explicit that the federal government could withhold new funding: “Today’s holding does not affect the continued application of §1396c to the existing Medicaid program. Nor does it affect the Secretary’s ability to withdraw funds provided under the Affordable Care Act if a State that has chosen to participate in the expansion fails to comply with the requirements of that Act.” Supreme Court, *National Federation*, 56.

68. Social Security Act, “Demonstration Projects.”

69. Kathleen Sebelius, “Progress Continues in Setting Up Health Insurance Marketplaces,” *HealthCare* (blog), HealthCare.gov, December 10, 2012, <http://www.healthcare.gov/blog/2012/12/marketplaces121012.html>.

expansion unless certain favorable terms, including not only higher FMAP rates but also other new administrative flexibility, are extended. A number of governors have already argued for additional flexibility in administering their Medicaid programs, suggesting a significant bargaining chip in future federal–state discussions of Medicaid expansion.<sup>70</sup> This consideration is particularly important for states in the context of the ACA’s intended coverage expansion because other provisions of the ACA, for example its Maintenance of Effort provision, would constrain state administrative flexibility.

In sum, states face complex and difficult decisions over whether to expand Medicaid coverage to include childless adults with incomes up to 100 percent of the FPL. They must weigh the positive value they associate with expanded Medicaid coverage against the amount by which such expansion would add to costs already projected to rise dramatically under previous law. States must also take into account whether they are able to negotiate additional flexibility in how they operate their Medicaid programs, as well as their degree of confidence that currently scheduled levels of federal support will be maintained.

#### VIII. HOW RELIABLE IS PROJECTED FEDERAL FINANCING SUPPORT FOR MEDICAID?

ANALYSIS TO THIS point of the paper has been based on the assumption that the federal government will maintain the full amount of scheduled financing support specified under current law. In determining whether to expand Medicaid, however, states must also consider the likelihood that federal financing support may ultimately be reduced from current schedules, shifting additional costs to states.

From a practical perspective, it is quite unlikely that the federal government will make the full amount of Medicaid payments now scheduled under law. The federal government has now run four consecutive years of unsustainable deficits exceeding

70. Letter from 29 Republican governors to US Senator Orrin Hatch and Chairman Fred Upton, June 13, 2011, <http://www.rga.org/homepage/gop-govs-unveil-medicaid-reform-principles/>. Excerpts:

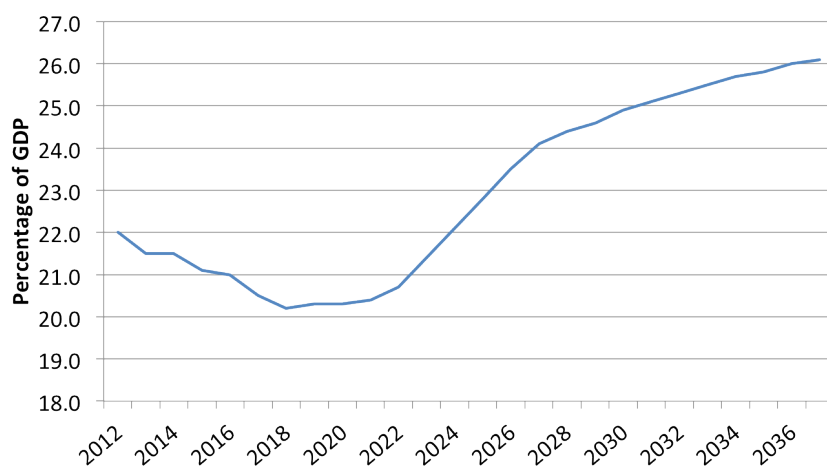
States and territories are best able to make decisions about the design of their healthcare systems based on the respective needs, culture and values of each state. . . . States and territories should also have the opportunity to innovate by using flexible, accountable financing mechanisms that are transparent and that hold states accountable for efficiency and quality healthcare. Such mechanisms may include a block grant, a capped allotment outside of a waiver, or other accountable and transparent financing approaches. . . . States and territories can provide Medicaid recipients a choice in their healthcare coverage plans, just as many have in the private market, if they are able to leverage the existing insurance marketplace through innovative support mechanisms. . . . States must have greater flexibility in eligibility, financing and service delivery in order to provide long-term services and support that keep pace with the people Medicaid serves.

See also Kyle Cheney, “GOP Governors Name Their Price on Medicaid Expansion,” *Politico*, July 14, 2012, <http://www.politico.com/news/stories/0712/78499.html>. The article mentions block-granting of federal Medicaid funds as a policy option potentially attractive to state governors.

\$1 trillion annually; most influential national policy makers and analysts acknowledge the need for substantial changes to current policies to avoid uncontrolled debt growth in future years.<sup>71</sup> If current policies continue to be observed and extended, within a quarter century federal debt held by the public is projected to grow from 73 percent of GDP to 199 percent and federal interest payments from 1.4 percent of GDP annually to 9.5 percent, reflecting an unsustainable rate of debt accumulation.<sup>72</sup>

Medicaid, CHIP, and the ACA’s new health exchange subsidies are leading contributors to the mounting federal fiscal problem, such that it is unrealistic to expect that federal deficits can be contained without these programs’ growing costs being scaled back. The CBO projects that through 2037, federal noninterest spending would grow from 22.0 percent of GDP to 26.1 percent under current policy, with nearly half of the growth relative to GDP being attributable to growth in these programs alone.<sup>73</sup> Figure 4 illustrates this projection.

**FIGURE 4. PROJECTED FEDERAL NONINTEREST SPENDING (CURRENT POLICY SCENARIO, AS A PERCENTAGE OF GDP)**

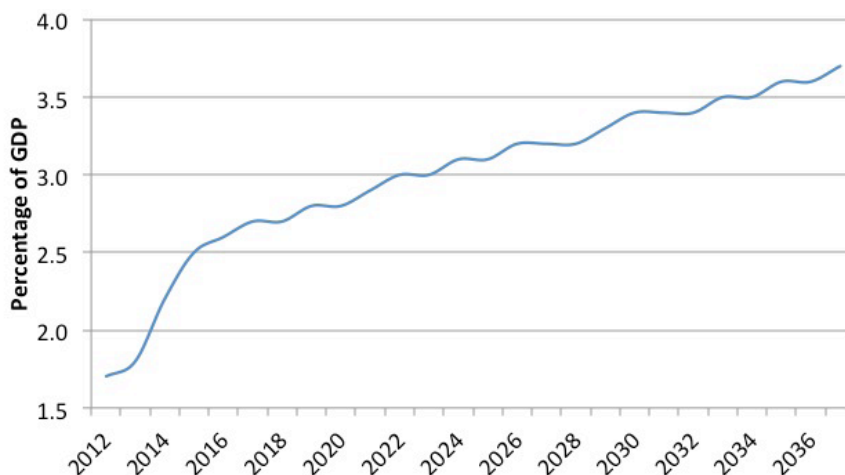


Source: CBO, “The 2012 Long-Term Budget Outlook,” June 2012, [http://www.cbo.gov/sites/default/files/cbofiles/attachments/06-05-Long-Term\\_Budget\\_Outlook\\_2.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/06-05-Long-Term_Budget_Outlook_2.pdf).

71. The CBO maintains two baseline projections of future federal finances, the “extended baseline” scenario representing literal current law and the “alternative fiscal policy” scenario representing the continuation of current policies, meaning in many instances the extension of current-law provisions now scheduled to expire. The two scenarios are identical with respect to Medicaid spending. The phrase “current policies” is employed in the main text of this paper because the statement in the text refers to the CBO scenario in which current policies continue to be extended.
72. CBO, “The 2012 Long-Term Budget Outlook,” June 2012, 12, [http://www.cbo.gov/sites/default/files/cbofiles/attachments/06-05-Long-Term\\_Budget\\_Outlook\\_2.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/06-05-Long-Term_Budget_Outlook_2.pdf).
73. The CBO’s long-term projections do not separate Medicaid costs from the costs of the new exchanges.

Even today's total noninterest spending level of 22.0 percent of GDP is higher than can be sustained over the long term without imposing unprecedented levels of taxes and/or federal debt, suggesting that spending restraints will be required not only relative to future projections but also relative to *current* elevated levels as a percentage of GDP. To return the federal budget to sustainable historical norms in the absence of any cuts in the growth of Medicaid and the new health exchanges would require all other noninterest spending to be cut by nearly one-quarter by 2037 relative to projected levels, and by roughly 15 percent relative to current levels in relation to GDP.<sup>74</sup> This is probably unrealistic. Figure 5 shows projected federal spending on Medicaid, CHIP, and the ACA's health exchanges under current policy.

FIGURE 5. PROJECTED FEDERAL SPENDING ON MEDICAID/CHIP, HEALTH EXCHANGES (CURRENT POLICY SCENARIO, AS A PERCENTAGE OF GDP)



Source: CBO, "The 2012 Long-Term Budget Outlook," June 2012, [http://www.cbo.gov/sites/default/files/cbofiles/attachments/06-05-Long-Term\\_Budget\\_Outlook\\_2.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/06-05-Long-Term_Budget_Outlook_2.pdf).

There also appears to be general bipartisan agreement that the current path of federal Medicaid spending is unsustainable and must be slowed. Constraints on Medicaid spending growth have been proposed in President Obama's submitted budgets, in the recommendations of the bipartisan Simpson–Bowles Commission, and in the budget resolution passed by the House of Representatives in 2012.<sup>75</sup> The

74. CBO, "The 2012 Long-Term Budget Outlook." The calculation assumes that federal noninterest spending is stabilized at 21 percent of GDP (still higher than historical norms, in which total spending including interest has averaged 21 percent of GDP).
75. The White House, Office of the Press Secretary, "Fact Sheet: The President's Framework for Shared Prosperity and Shared Fiscal Responsibility," news release, April 13, 2011, <http://www.whitehouse.gov/the-press-office/2011/04/13/fact-sheet-presidents-framework-shared-prosperity-and-shared-fiscal-resp>; President's Commission on Fiscal Responsibility, "Co-chairs' Proposal," November 2010; Chairman Paul Ryan, "The Path to Prosperity," Fiscal Year 2013 Budget Resolution, March 20, 2012, <http://paulryan.house.gov/uploadedfiles/pathtoprosperity2013.pdf>.



amount of projected cost savings varies widely between these proposals, but each of them would trim at least \$100 billion from the projected cost of Medicaid over the upcoming decade. During bipartisan budget negotiations in the summer of 2011, the two sides had also reached a conceptual agreement to pursue Medicaid savings of at least this magnitude.<sup>76</sup> The bare minimum of federal Medicaid spending reductions that must be achieved over the next decade appears to be \$100 billion, while practical budgetary considerations suggest that substantially greater savings will be needed.

Reductions in scheduled federal Medicaid payments would not necessarily mean that the ACA's enhanced FMAP rates would be reduced. Historically, FMAP rates have remained relatively stable, though they have been adjusted with the changing demographics of each state and have seen occasional periods of increased federal assistance.<sup>77</sup> There are, however, a variety of other methods available to the federal government to reduce its own Medicaid expenditures while increasing the share of Medicaid spending financed by states.<sup>78</sup>

Though reductions in the growth of federal Medicaid spending are nearly certain, the extent to which they would result in increased state Medicaid costs cannot be precisely quantified. Opponents of specific federal cost-containment proposals often animate opposition among state advocates by presenting analyses assuming that every dollar in federal savings results in a dollar of costs being passed to states.<sup>79</sup> This author strongly disagrees with such analyses, which hold implicitly that the best course for Medicaid beneficiaries and for states is that federal costs never be slowed from the current unsustainable path. Instead, implementing structural Medicaid reforms that empower states to employ market forces to improve

76. Slides describing the points of agreement in the "Biden Framework" later circulated by House Majority Leader Eric Cantor.
77. US Department of Health and Human Services, "Federal Percentages and Federal Medical Assistance Percentages, FY 1961–2011, <http://aspe.hhs.gov/health/fmapyearly.htm>.
78. For example, a number of budget proposals, including both President Obama's budget submission and Republican proposals, would reduce states' latitude to finance Medicaid expenditures through taxes on providers. See White House, "President's Framework": "The framework would clamp down on States' use of provider taxes to lower their own spending while not providing additional health services through Medicaid."
79. In "National State-by-State Impact of the 2012 House Republican Budget Plan for Medicaid," Kaiser Commission, October 2012, <http://www.kff.org/medicaid/upload/8185-02.pdf>, authors John Holahan et al. evaluate two scenarios, prominently highlighting one in which all federal cost constraints are passed to the states with no reductions in the rate of per-enrollee Medicaid cost growth. In "Paul Ryan Is Thoughtful, Handsome and Misguided," *Bloomberg*, August 11, 2012, <http://www.bloomberg.com/news/2012-08-11/paul-ryan-is-thoughtful-handsome-and-misguided.html>, Peter Orszag assumes that proposals for block-granting Medicaid will be unsuccessful in constraining the growth of total Medicaid costs, and thus hypothesizes that states will be "on the hook" for the federal cost constraints. In "HHC Shows How Bad Medicaid Cuts Would Be," November 10, 2011, <http://www.sseu371.org/news/4-hhc-shows-how-bad-medicaid-cuts-would-be-2504>, Social Service Employees Union 371 states that President Obama's Medicaid proposal (which did include FMAP changes) "merely shifts costs to states."

efficiencies, while also reducing the growth of federal Medicaid spending, could decelerate total Medicaid expenditure growth rather than simply shifting costs between federal and state governments. A number of governors have publicly expressed support for such structural reforms as the keys to whether state governments will be able to handle projected caseload increases including the Medicaid coverage expansion envisioned in the ACA.<sup>80</sup>

Clearly, however, state governments do remain at risk that the federal government will take further steps to reduce its own Medicaid costs without facilitating more fundamental structural reform of the program. The minimum level of such cost reductions appears to be at least \$100 billion over the next 10 years, with some bipartisan deliberations agreeing to closer to \$200 billion.<sup>81</sup> Even if less than one-half of \$200 billion in federal cost containment were passed to the states, they would already be facing cost increases over and above current law as large as their entire incremental cost increase associated with the ACA.<sup>82</sup>

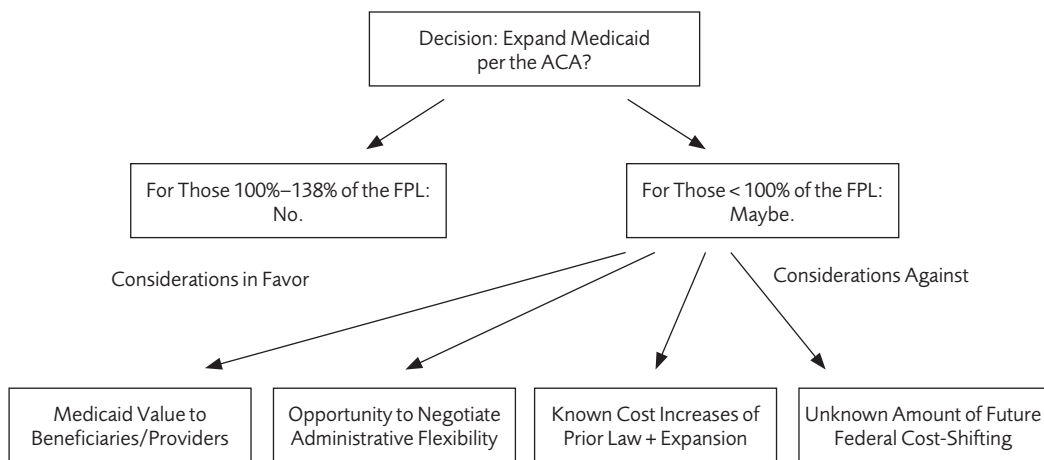
States cannot therefore afford to assume that their Medicaid cost increases will be limited to those directly spelled out in the language of the ACA. They face substantial projected Medicaid cost increases under prior law as well as other unspecified but reasonably likely shifts of costs currently borne by the federal government. State governments must look to rein in their own cost growth relative to virtually any plausible federal legislative scenario. In this context, it is unsurprising that a number of states continue to defer their decisions on Medicaid expansion until the federal fiscal picture is further clarified.

## IX. CONCLUSION

THE 2012 SUPREME COURT decision changed the policy landscape surrounding the ACA from one of essentially compulsory Medicaid expansion to one in which states face complex, finely balanced decisions. The flow chart in figure 6 summarizes some of the states' competing considerations described in this paper.

80. The perceived need for flexibility in pursuing such reforms is at the root of the June 13, 2011, letter from 29 Republican governors.
81. See President's Commission on Fiscal Responsibility, "Co-chairs' Proposal." Proposals to save closer to \$100 billion were floated by the Obama administration and in the 2011 bipartisan budget negotiations, but in the context of proposals that would be inadequate to stabilize federal finances. See also White House, "President's Framework," and slides describing the points of agreement in the "Biden Framework" later circulated by House Majority Leader Eric Cantor.
82. Recall CMS, "2011 Actuarial Report," in which the projected state cost increase associated with the ACA was \$64 billion through 2020.

FIGURE 6. DECISION TREE STATE GOVERNMENTS FACE



In the wake of the 2012 Supreme Court ruling, states face complex decisions concerning whether to expand Medicaid coverage to the full extent envisioned in the ACA. With the federal government no longer able to coerce full expansion via the withholding of existing Medicaid funding, states must base their decisions on subjective policy value judgments that will vary from state to state, incorporating each state's unique budgetary circumstances, the specific needs of its own uninsured population, and the incentives established by interactions among the ACA's various provisions. These decisions are not trivial and require the careful balancing of powerful conflicting considerations. In contrast with some statements made by both supporters and opponents of the ACA, the complexities of these decisions suggest that states should be expected to make a wide variety of policy choices.

States generally face substantial near-term Medicaid cost increases irrespective of decisions made regarding the ACA. Much of this projected increase reflects case-load and the growth of per-enrollee Medicaid costs, though some of it also derives from the expiration of temporary emergency assistance provided to states during 2009–11 in federal stimulus legislation.

States do all appear to face one common, powerful incentive arising from the court's ruling: to decline to cover childless adults at or above the FPL under Medicaid. By so doing, states will minimize their own budgetary exposure while leaving these individuals eligible for new health insurance exchanges established by the ACA and shifting the costs of their coverage to the federal government. This policy would also appear to maximize potential benefits for the individuals in this income range; the amount of total government subsidies as well as the overall generosity of insurance coverage are projected to be greater for such individuals if participating in the exchanges than they would be under Medicaid. Substantial reductions in the scheduled growth of federal subsidies for the exchanges would likely

be required to dampen state incentives to have individuals with incomes above the FPL covered through the exchanges rather than through Medicaid.

With respect to childless adults with incomes below 100 percent of the FPL, decisions are more complicated. Projections indicate that even if the high FMAP rates of the ACA were provided for a partial expansion, covering newly eligible individuals as well as increased numbers of those previously eligible will add to state budget costs relative to their current expenditures on health services for the uninsured.

HHS's recent announcement that the ACA's enhanced FMAP rate will not apply to a partial expansion considerably reduces state incentives to expand Medicaid at all. For many states to find it attractive to expand Medicaid coverage to 100 percent of the FPL would likely require the federal government either to deem such an expansion as compliant with Medicaid law, to grant the requisite waivers, or to find another regulatory path to partial-expansion states receiving the ACA's enhanced FMAP rate. The degree of flexibility provided to state governments in administering such a coverage expansion is also likely to be a critical factor in state decisions. In the end, subjective policy value judgments and local factors are likely to lead to divergent decisions by states as to how much of the childless population below 100 percent of the FPL is covered.

States must also factor in the near certainty that future federal support for Medicaid will be constrained relative to current law projections. The amount of resultant cost-shifting to states is unknown at this time, but it is reasonable for states to believe that it could result in their carrying additional costs of the same order of magnitude as the ACA's coverage expansion. For this reason, many states will find it prudent to defer their decision-making on the ACA as long as possible, seeking to maximize clarification of federal fiscal practices before further long-term commitments are made.