

THE ECONOMICS OF MEDICAID

Assessing the Costs and
Consequences

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CHAPTER 5: MEDICAID UNDER THE AFFORDABLE CARE ACT

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The 2010 passage of the Patient Protection and Affordable Care Act (PPACA), more commonly referred to as the Affordable Care Act (ACA),¹ vastly increased projected Medicaid costs. One of the core objectives of the ACA was to expand considerably the ranks of Americans with health insurance coverage, with Medicaid serving as the primary vehicle for covering the previously uninsured poor. The ACA's expansion of Medicaid coverage will cause Medicaid costs to increase significantly, with these increases concentrated on the federal share of total Medicaid expenditures.

The ACA dramatically expanded the numbers of those eligible for Medicaid coverage by mandating that participating states offer coverage to all childless adults with incomes below 133 percent of the federal poverty level (FPL). The income eligibility threshold was effectively set at 138 percent of FPL by another statutory provision that established a 5 percent income exclusion.²

The federal government attempted to cushion the financial blow that this dramatic coverage expansion would embody for the states by financing with federal funds 100 percent of Medicaid costs for the

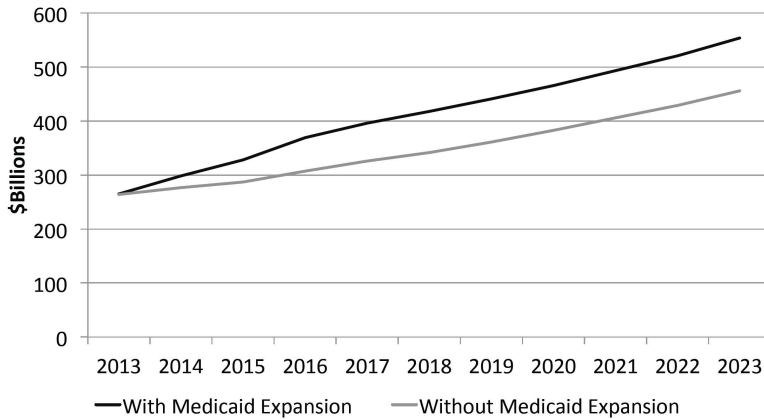
newly eligible population in the first three years of 2014–16, a percentage that will gradually decline to 90 percent by the year 2020.

Medicaid is a joint federal–state program in which state participation is technically voluntarily; the federal government cannot constitutionally force states to participate, though all states do. But at the same time, the federal government—through the auspices of the secretary of Health and Human Services (HHS)—has the statutory power to deny federal Medicaid funding to a state if the secretary determines that it is not in compliance with federal Medicaid law’s benefit and eligibility requirements.³ With the ACA having expanded Medicaid’s mandatory coverage standards, the federal government essentially gave itself the power to deny Medicaid funding to any state that did not fully participate in the expansion. The only alternative to full expansion left to the states per the language of the ACA was the politically implausible one of ending their participation in Medicaid altogether.

This dynamic was changed significantly by the US Supreme Court’s June 2012 ruling on the constitutionality of the ACA. The court upheld most of the ACA’s provisions, most notably its requirement that individuals carry health insurance or be subject to a new federal tax.⁴ But in the same ruling, the court struck down the federal government’s ability to enforce its mandated Medicaid expansion by withholding existing Medicaid funds from states that declined to comply. By eliminating the federal government’s power to enforce it, the court’s action effectively made the ACA’s Medicaid expansion optional for the states.

The court’s decision changed estimates of the projected cost of the ACA, and in particular of its Medicaid expansion provisions. Prior to the decision, it was generally assumed that all states would participate in the expansion. Afterward, because of the conflicting incentives facing states in the wake of the court ruling as well as policy decisions announced by many state governments around the nation, it became clear that some states would not participate in the Medicaid expansion.⁵ But until all states have announced and implemented their decisions, Medicaid expansion participation levels can only be very roughly estimated. The Congressional Budget Office’s (CBO’s) latest

Figure 1. Projected Federal Medicaid Costs, With and Without ACA Medicaid Expansion



Note: Cost projections are based on CBO assumptions regarding state participation.

Sources: Congressional Budget Office, "CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage," table 2, May 2013; Congressional Budget Office, "Medicaid Spending and Enrollment Detail for CBO's May 2013 Baseline," May 2013.

estimates are that two-thirds of potentially newly eligible individuals reside in states that will voluntarily participate in the ACA expansion, resulting in a total Medicaid coverage increase of 13 million by 2021, on top of a baseline estimate of 34 million projected in the absence of the ACA.⁶ This expansion would in turn add \$87 billion annually to federal Medicaid and Children's Health Insurance Program (CHIP) outlays by 2021, bringing total federal Medicaid expenditures in that year to \$493 billion.⁷

In effect, CBO anticipates that the ACA's Medicaid expansion, even if only partially implemented by the states, will add more than 21 percent to annual federal Medicaid costs by 2021. These cost increases will be added to federal Medicaid costs that were already projected to rise substantially even before the ACA's Medicaid expansion was enacted, as shown in figure 1.

CBO's projections are similar to those made by other federal estimators, including the Chief Actuary of the Centers for Medicare and

Medicaid Services (CMS). In its 2012 actuarial report, the Office of the Chief Actuary estimated that federal Medicaid costs will reach \$478 billion annually by 2021.⁸ This is based on an assumption that in 2014, 55 percent of the potentially newly Medicaid-eligible population will reside in states that choose to expand, a percentage rising to 65 percent in 2015 and thereafter. This participation assumption is just slightly lower than the two-thirds assumption on which CBO had based its estimates after the 2012 Supreme Court decision.⁹

The CMS projections also reveal how Medicaid costs would rise still more dramatically if all states were to participate in the full Medicaid expansion envisioned in the ACA. The CMS baseline estimate of \$478 billion of federal Medicaid costs in 2021 translates to a total Medicaid cost of roughly \$795 billion in that year (federal financing being 60 percent of the total). CMS projects that if all states participate in the ACA's Medicaid expansion, total program costs will rise still further in that year to roughly \$831 billion.¹⁰

It is widely acknowledged that federal Medicaid costs are on an unsustainable trajectory, even apart from the issue of the ACA's Medicaid expansion.¹¹ Along with Medicare and Social Security, the new health coverage obligations arising under the ACA embody the main categories of federal spending projected to grow over the long term at rates faster than the federal tax base can sustain.¹² Accordingly, every recent and significant bipartisan discussion of how to best address the federal budget deficit has prompted proposals to reduce the rate of growth of federal Medicaid expenditures. The amount of savings envisioned in these various budget proposals varies significantly, but all reflect a shared bipartisan understanding that projected federal Medicaid cost growth will need to be scaled back.

EFFECTS OF MEDICAID EXPANSION ON STATE BUDGETS

The 2012 Supreme Court decision left states with the voluntary option of considerably expanding their Medicaid rolls to cover all childless

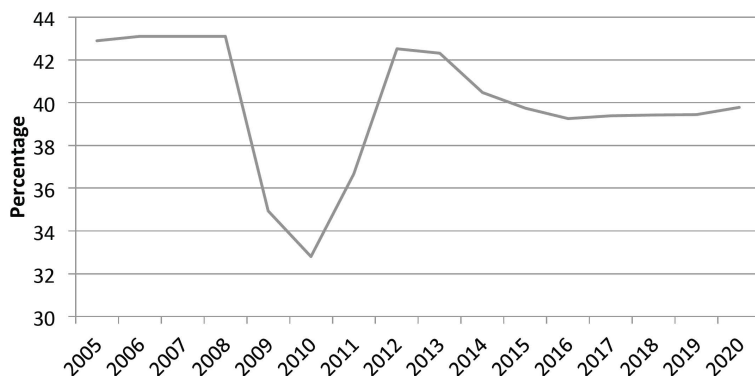
adults with incomes effectively up to 138 percent of the FPL. In effect, the Medicaid expansion is an opportunity for states to significantly expand health benefits for their own citizens while passing the vast majority of the bill to federal taxpayers who mostly reside in other states. But at the same time, states will themselves face substantial additional costs if they choose to expand.

The expansion decision arrives at a time when state budgets are already under severe strain as a result of the recent recession as well as the mounting costs arising under Medicaid to date. Total state-financed Medicaid expenditures rose from roughly \$31 billion in 1990 to roughly \$157 billion in 2011, even though the federal share of total Medicaid costs had risen over the same period from 57 percent to 63 percent.¹³ A survey of state budgets showed that already by 2011, state-financed Medicaid expenditures accounted for nearly 24 percent of state budgets.¹⁴

The fact that the federal government picked up 63 percent of total Medicaid costs in 2011 is significant for state decision making going forward. The percentage of total Medicaid costs financed from federal funds in that year was kept artificially high—and thus, state-financed expenditures held artificially low—as a result of temporary assistance provided to states through the 2009 federal stimulus law. In 2009, 2010, and 2011, effective federal financing assistance percentages averaged 65 percent, 67 percent, and 63 percent respectively, each annual percentage being substantially higher than the long-term average of 57 percent. As a result, even states that participate in the ACA's Medicaid expansion must actually finance a higher share of total Medicaid expenditures in the future than they did during the 2009–11 period, despite the generous federal financing assistance percentages promised under the ACA, as reflected in figure 2.¹⁵

Partially as a result of the expiration of temporary stimulus assistance, and partially as a result of rising caseload and general health care cost inflation, states face substantial Medicaid cost increases irrespective of their decisions about whether to expand Medicaid per

Figure 2. State Share of Total Medicaid Expenses (Compared to the 2009–11 Stimulus Period)



Source: Office of the Actuary, Centers for Medicare and Medicaid Services, "2012 Report on the Financial Outlook for Medicaid," 2012, table 3.

the terms of the ACA. Some estimates find that expansion would further increase state Medicaid costs by only roughly 3 percent, but this modest incremental increase would still create additional fiscal pressure at a particularly inopportune moment for states.¹⁶ Current CMS estimates are that total state Medicaid costs will rise by 125 percent from 2010 to 2020 based on updated assumptions for partial state participation in the ACA's Medicaid expansion.¹⁷ Even by Medicaid standards, this is an extremely rapid rate of cost growth, representing a substantial acceleration in state-financed costs relative to the 2000–10 period.¹⁸

Some advocates of expansion have argued that the ACA's generous promises of federal support for Medicaid expansion, combined with the fact that states currently face substantial costs for the treatment of the uninsured, together mean that states could actually save money by choosing to expand Medicaid. Although reducing the cost of treating the uninsured is an important factor to weigh as states contemplate Medicaid expansion, the available data do not appear to support the suggestion of net cost savings. On average, states should

expect their total expenditures to rise significantly if they expand Medicaid.

A Henry J. Kaiser Foundation study found that roughly 33 percent of the cost of treating the uninsured is “uncompensated,” with these costs in turn distributed between entities that include the federal government as well as state governments.¹⁹ Taken together, the data suggest that roughly 10.6 percent of the total cost of treating the uninsured is financed by state governments. Taking into account the phenomenon under which individuals with insurance tend to purchase more health care services than those without, states on average would need to face no more than 8 percent of the cost of covering the newly Medicaid-insured in order to come out ahead fiscally.²⁰ In other words, an effective FMAP (federal medical assistance percentage) rate of 92 percent for the entire coverage expansion population would be required to allow expansion to be a fiscal gain for the states, on average.

Under the terms of the ACA, the federal government is promising to fund 90 percent of the cost of covering the newly eligible population from 2020 onward. This, however, substantially overstates the share of expansion costs that the federal government will actually pay, due largely to a phenomenon known as the “woodwork effect.”

The woodwork effect is so called because it is expected that many people who were already eligible for Medicaid but had not previously signed up will emerge “out of the woodwork” to claim Medicaid benefits as coverage is expanded. This expectation is based in part on the ACA’s outreach processes under which previously eligible individuals are to be enrolled in Medicaid if they attempt to sign up for the ACA’s new health exchanges.²¹ The ACA’s imposition of a tax on those without health insurance is also expected to increase Medicaid enrollment among the eligible population. CBO estimates that roughly one-third of those with incomes below the FPL who receive Medicaid coverage under the ACA will be individuals who were eligible under prior law.²²

Importantly, previously eligible individuals would not trigger federal support at the generous financing assistance rates of the ACA, but rather at the lower levels that existed in pre-ACA law. On average, the

federal government has paid 57 percent of the cost of Medicaid coverage for those previously eligible. Putting all these numbers together, it should be expected that over the long term, states will need to shoulder roughly 21 percent of the cost of financing expanded Medicaid coverage for those in poverty. This is substantially more than the estimated break-even level of 8 percent.

The 21 percent figure is a rough average estimate of states' share of the added financing burden. Percentage financing burdens would vary significantly by state. States that historically have had higher uninsured percentages among those with incomes below the FPL, such as Texas, Nevada, and Montana, would likely experience proportional cost increases that are higher than this average.²³

As states confront this decision, they must also factor in the previously mentioned consensus that the growth of federal Medicaid expenditures will need to be slowed. At this time, no person can state with certainty how much federal Medicaid expenditures will be reduced from current schedules, nor how much of these costs will be passed to states rather than embodying absolute reductions in the growth of total Medicaid costs. It would be unrealistic, however, for states to assume in their fiscal planning that federal expenditure schedules will be unchanging going forward.

INTERACTIONS BETWEEN PROVISIONS OF THE ACA

The particulars of the 2012 Supreme Court decision created unintended interactions between various provisions of the ACA, producing what appears to be a common incentive now facing all states: specifically, to decline to cover childless adults with incomes above the FPL under Medicaid.

This common incentive is an unintended consequence of the legislation's course first through Congress and later through the Supreme Court.²⁴ By original design, the ACA was intended to dramatically expand health coverage by a variety of methods. Individuals were to be subjected to a federal tax or penalty if they did not carry health

insurance; employers (other than the smallest businesses) were generally to be assessed a penalty if they did not provide health insurance to their employees; states were to be required to cover childless adults with incomes of up to 138 percent of the FPL under Medicaid; and those with incomes between 100 and 400 percent of the FPL, if they lacked Medicaid coverage or an affordable employer offer of health insurance, were to be provided with substantial federal subsidies to purchase health insurance through the ACA's new exchanges.

These various features of the ACA were all intended to work in tandem. Federal subsidies for participants in the health exchanges were devised to be most generous for those with incomes between 100 and 133 percent of the FPL, effectively capping these low-income individuals' health insurance premiums in the exchanges at no more than 2 percent of their annual income.²⁵ But it was not expected that most such individuals would be drawing on these generous federal subsidies, given that states were required to cover those with incomes below 138 percent of FPL under Medicaid and that eligibility for the subsidies was extended only to those who were not otherwise Medicaid-eligible.²⁶

This dynamic changed with the 2012 Supreme Court decision. Suddenly, states were no longer required to cover this population under Medicaid, leaving the subset of these individuals with incomes above the FPL potentially free to buy their health insurance through the exchanges with substantial federal support.

States have obvious financial incentives to have the federal government subsidize these individuals through the ACA's health exchanges. If the individuals are covered under Medicaid, states will eventually be required to finance 10 percent of the cost of their coverage under current law. If instead the individuals are covered through the exchanges, the entire subsidy would be financed by the federal government.²⁷

The evidence further suggests that not only would declining to cover these individuals under Medicaid embody a cost savings for states, but that states could potentially provide the individuals with access to more generous health insurance through the exchanges, if they are left uninsured by Medicaid. Under 2012 CBO estimates,

total average annual insurance value in 2022 for individuals in this income range would be roughly \$9,500 in the exchanges, but less than \$7,000 under Medicaid, with federal subsidies of roughly \$9,000 in the exchanges and \$6,000 under Medicaid.²⁸

Taken together, these incentives suggest that leaving the population with incomes above the FPL uncovered by Medicaid is a win-win for states, delivering both cost savings as well as potentially more generous health coverage for their citizens. In recognition of this reality after the Supreme Court decision, CBO singled out 100 percent of the FPL as the income threshold at which states would lose their incentive to expand Medicaid:

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.²⁹

In the same report, CBO also projected that covering individuals only up to 100 percent FPL under Medicaid would be the most common choice made by states, although federal regulatory guidance was not then available as to whether states could make this partial-expansion choice. For their part, states perceived that their incentives pointed in this direction immediately after the Supreme Court decision. A letter sent by the National Governors Association just after the ruling on July 2, 2012, to HHS Secretary Kathleen Sebelius asked

whether states that expanded up to 100 percent of FPL would still receive the ACA's enhanced federal assistance percentage.³⁰

The aftermath of the Supreme Court decision displays the leverage of both sides in the federal–state discussion of the possible expansion of Medicaid. The federal government has the power to determine whether states are in compliance with Medicaid coverage requirements, and thus far has held to an interpretation that states must expand fully to 138 percent of the FPL to receive the enhanced federal assistance percentage under the ACA. At the same time, powerful incentives and leverage are pulling in the other direction. As we have seen, states have an enormous incentive to decline to cover those above 100 percent of the FPL under Medicaid, plus the federal government cannot force them to expand either fully or in part; the ultimate expansion decision rests with the states. Further shoring up the states' leverage, the language of the ACA specifies that its enhanced federal assistance percentage will be provided for any “newly eligible” recipient, defined in the statutory text as all those made eligible per the terms of the ACA who were not already eligible at the time the ACA was enacted.³¹

The interaction of these various provisions of the ACA with the recent Supreme Court decision creates a delicate balance of considerations, such that it is unsurprising that states are now making a wide range of decisions based in part on whether they believe they can negotiate satisfactory expansion terms in their discussions with HHS. This wide array of state coverage decisions reflects states' distinct value judgments and respective budgetary and demographic situations, but ultimately the incentives against covering those with incomes above 100 percent of FPL are powerful and appear to be common to all states. For the reasons discussed throughout this chapter, it is likely that with the passage of time and the continued escalation of Medicaid costs, an increasing number of states will conclude that it is in their interest for their citizens with incomes above the FPL to be covered through the health exchanges solely at federal expense.

CONCLUSION

The passage of the ACA in 2010 will dramatically increase total Medicaid expenditures, though how much of an increase will be a function of individual state decisions (many yet to be made) in the wake of the 2012 Supreme Court ruling. The Supreme Court rendered the ACA's expansion of Medicaid optional for states by striking down the federal government's ability to enforce it by withholding existing Medicaid funding. Federal Medicaid expenditures will rise sharply in the years ahead in any event, though far more dramatically to the extent that states choose to expand Medicaid coverage.

States' decisions about whether to expand Medicaid in the aftermath of the Supreme Court ruling are complex and closely balanced. Despite the arguments of some advocates that expanding Medicaid will reduce state costs of treating the uninsured, the available data do not appear to support the suggestion of net cost savings for states. On average, states should expect their total expenditures to rise significantly if they choose to expand Medicaid. These state expansion costs arise because their shares of Medicaid obligations for the expansion population are projected to significantly exceed savings with respect to their current costs of care for the uninsured. Such new costs of expansion would accrue at a time when Medicaid expenditures are already straining state budgets, on top of increasing baseline cost obligations that are a consequence of rising Medicaid caseloads, continuing health care cost inflation, and the wearing away of recent federal stimulus assistance.

Apparently common to all states is a disincentive to expand Medicaid to individuals with incomes above the FPL, as these individuals—if left uninsured by Medicaid—will be eligible for more generous coverage through the ACA's health exchanges with subsidies financed entirely by the federal government. With the passage of time and as general Medicaid costs rise, it appears likely that more states will feel compelled to respond to this incentive by limiting Medicaid coverage for childless adults solely to those with incomes below the FPL.

NOTES

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended sections of 42 U.S.C.).
2. Office of the Actuary, Centers for Medicare and Medicaid Services, "2012 Report on the Financial Outlook for Medicaid" (Department of Health & Human Services, 2012), 2, <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2012.pdf>.
3. Social Security Act, 42 U.S.C. § 1396c, "Operation of State Plans," http://ssa.gov/OP_Home/ssact/title 19/1904.htm.
4. National Federation of Independent Businesses et al. v. Sebelius, 132 S. Ct. 2566 (2012).
5. The Advisory Board Company maintains a running tally of state participation decisions at <http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap>. As of May 24, 2013, this survey found that 26 states had indicated participation, 1 was leaning toward participation, 4 were pursuing an alternative model, 6 were leaning against participation, and 13 had declined to participate.
6. Congressional Budget Office, "CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage" (Washington, DC: Government Printing Office, May 2013), table 1, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf.
7. Congressional Budget Office, "CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage" (Washington, DC: Government Printing Office, May 2013), table 2, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf; Congressional Budget Office, "Medicaid Spending and Enrollment Detail for CBO's May 2013 Baseline," May 2013, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44204_Medicaid.pdf.
8. Office of the Actuary, Centers for Medicare and Medicaid Services, "2012 Report on the Financial Outlook for Medicaid," table 3.
9. Congressional Budget Office, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision," July 2012.
10. Office of the Actuary, "2012 Report on the Financial Outlook for Medicaid," 39.
11. Charles Blahous, "The Affordable Care Act's Optional Medicaid Expansion: Considerations Facing State Governments" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, March 5, 2013), 30–34, <http://mercatus.org/publication/affordable-care-acts-optional-medicaid-expansion-considerations-facing-state-governments>.
12. Congressional Budget Office, "The Long-Term Budget Outlook" (Washington, DC: Government Printing Office, June 2012), 13, <http://www.cbo.gov/publication/43288>: "Under CBO's two scenarios, the projected growth in noninterest spending as a share of GDP over the long term stems from increases in mandatory spending, particularly in outlays for the government's major health care programs: Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the insurance subsidies that will be provided through the exchanges created under the Affordable Care Act (ACA). Under both scenarios, total outlays for those health care programs would grow much faster than GDP, increasing from 5.4 percent of GDP in 2012 to about 10 percent in 2037."
13. Office of the Actuary, "2012 Report on the Financial Outlook for Medicaid," 2012,

- table 3, <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2012.pdf>.
14. 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," 2011, <http://www.nasbo.org/sites/default/files/2010%20State%20Expenditure%20Report.pdf>.
15. The most recent projection data presented in figure 2 reflect CMS assumptions with respect to state participation in the Medicaid expansion as made in Office of the Actuary, "2012 Report on the Financial Outlook for Medicaid," table 3. That the statement is true specifically for states that participate in the Medicaid expansion is further substantiated by Centers for Medicare and Medicaid Services, "2011 Actuarial Report on the Financial Outlook for Medicaid," table 3, which shows a similar pattern under the different assumption that all states participate in the expansion.
16. Blahous, "The Affordable Care Act's Optional Medicaid Expansion," 20.
17. Office of the Actuary, "2012 Report on the Financial Outlook for Medicaid," table 3.
18. From 2000 to 2010, state-financed Medicaid costs grew cumulatively by approximately 48 percent. Blahous, "The Affordable Care Act's Optional Medicaid Expansion," 18.
19. 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>.
20. The aforementioned Kaiser study estimates that, if covered by Medicaid, these individuals' health care consumption would rise by roughly 39 percent. The full deviation of the 8 percent figure can be found in Blahous, "Affordable Care Act's Optional Medicaid Expansion," 26.
21. ACA, <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>.
22. Congressional Budget Office, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision," July 2012, <http://www.cbo.gov/publication/43472>.
23. Blahous, "The Affordable Care Act's Optional Medicaid Expansion," 27.
24. Some who have written about this history refer to this result more directly as a "mistake." See for example Dylan Scott, "The Story Behind the Biggest Mistake in Obamacare," *Governing.com*, February 2013, <http://www.governing.com/blogs/fedwatch/gov-obamacare-mistake.html>.
25. Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1001 (2010).
26. Scott, "The Story Behind the Biggest Mistake in Obamacare." "The ACA stipulates that an individual can't qualify for both Medicaid *and* a tax subsidy (as people between 100 and 138 percent of the federal poverty level technically would). To address that gap, the ACA said that anyone who qualifies for both would just automatically be enrolled in Medicaid. So why don't the thresholds simply meet at 138 percent? Well, they were supposed to, but because of an oversight while the bill was being amended in the Senate, they don't. But it didn't matter as long as the Medicaid expansion was mandatory, which it was always supposed to be. But then the Supreme Court ruled last June that the expansion wasn't required—states could choose whether or not to expand Medicaid eligibility to 138 percent of the poverty line. That's an outcome no one saw coming, not even the people who wrote the law. By making the Medicaid

expansion optional, the Court exposed this obscure mistake that had been buried in 906 pages of legislation. And it created a huge loophole: In states that aren't expanding Medicaid, those 'in-betweeners'—residents who make between 100 and 138 percent of the poverty line—will now qualify for tax subsidies to buy private insurance instead. 'It was unintentional,' said one person who was involved in drafting the bill in the Senate. Like other sources interviewed for this story, this person spoke on condition of anonymity in order to speak candidly about the error and private deliberations around the ACA. 'This strange confluence of events got us here. Nobody thought the Supreme Court would rule as it did,' the source said. 'If the Medicaid expansion had occurred as we wrote it, then this wouldn't have mattered. The number of turns in the plot was hard to anticipate.'"

27. These subsidies consist essentially of federal tax credits; beyond direct subsidy costs, states could face other administrative and information technology costs in the exchanges depending on who sets them up and how they are administered.
28. For a fuller derivation of these figures, see Blahous, "The Affordable Care Act's Optional Medicaid Expansion."
29. Congressional Budget Office, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision," July 2012, <http://www.cbo.gov/publication/43472>.
30. 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>. HHS's answer was effectively to say "no"; Letter from Secretary Kathleen Sebelius to governors, July 10, 2012, <http://www.ncsl.org/documents/health/GovLetter7-10.pdf>. However, HHS has subsequently allowed individual states to pursue proposals to effectively allow those above 100 percent of FPL to be enrolled in private insurance plans. See <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/02/28/arkansas-different-plan-to-expand-medicaid/>.
31. Sections 1905 and 1902 of the Social Security Act, http://ssa.gov/OP_Home/ssact/title19/1905.htm and http://ssa.gov/OP_Home/ssact/title19/1902.htm.

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