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Crafting a Narrative for the Red State Option

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Introduction

As of this writing, the Supreme Court's decision in the *Health Care Cases* is a little over a year old, and most states' 2013 legislative sessions have concluded. In *National Federation of Independent Business v. Sebelius* (NFIB),[2] the Court gave states the option to expand their Medicaid programs in accordance with the Affordable Care Act (ACA).[3] Since then, states have had a year to deliberate. It is thus an opportune time to assess the current state of play: Just over half the states, including eight with Republican governors, have agreed to expand Medicaid.[4] Another fourteen states have rejected expansion.[5] The rest, depending on whose analysis one reads, are leaning one way or are negotiating alternative paths to expansion with the federal authorities. This Article considers the future of *NFIB*'s "Red State Option"[6] and offers a narrative by which currently resistant states may come to accept Medicaid expansion.

Given that last summer more than half of the states were litigants challenging the constitutionality of Medicaid expansion before the Supreme Court,[7] perhaps this current status is not surprising. But it is surprising when one considers the extraordinarily good deal that the federal government is offering states that choose to expand. For the first three years, the federal government

1 Professor, University of Georgia Law School. I am grateful to Nicole Huberfeld for inviting me to contribute to this Symposium and to the other contributing authors for the stimulating discussion. I would also like to thank Kevin Outterson, Diane Hoffmann, and other participants at the University of Maryland's "State of the States" 2013 health reform roundtable for comments and suggestions to improve this paper.

2 NFIB v. Sebelius, 132 S. Ct. 2566 (2012).

3 *Id.* at 2608.

4 As of this article, twenty–six states have accepted Medicaid expansion. *Where Each State Stands on ACA's Medicaid Expansion*, Advisory Bd. Daily Briefing (June 14, 2013), http://www.advisory.com/Daily–Briefing/2012/11/09/MedicaidMap#lightbox/1/.

5 Carter C. Price & Christine Eibner, *For States that Opt out of Medicaid Expansion: 3.6 Million Fewer Insured and $8.4 Billion Less in Federal Payments*, 32 Health Aff. 1030, 1030 (2013) (listing Alabama, Georgia, Idaho, Iowa, Louisiana, Maine, Mississippi, North Carolina, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, and Wisconsin).

6 *See* Nicole Huberfeld, Elizabeth Weeks Leonard, & Kevin Outterson, *Plunging into Endless Difficulties: Medicaid and Coercion in* National Federation of Independent Business v. Sebelius, 93 B.U. L. Rev. 1, 6 (2013).

7 *See id.* at 30 & n.182 (noting that twenty–six states were among the litigants in Florida *ex rel.* Attorney Gen. v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235 (11th Cir. 2011), *aff'd in part, rev'd in part sub nom. NFIB*, 132 S. Ct. 2566 (2012)).

would pay 100% of the Medicaid expansion population's coverage.[8] After that, the federal government would pay 95% for three more years, then pick up 90% of the tab in perpetuity.[9] Without question, states would face a much steeper financial burden if they tried to cover the same uninsured population without federal support. States, nevertheless, complain that even the slight, incremental increased costs they would bear are unsustainable.[10]

But set the numbers aside. There are other dynamics at work. For many reluctant states, the issue cannot be easily resolved by referencing a balance sheet. There are fundamental principles of federalism and deeply held aversions to the expansion of federal authority that must be heeded. For states favoring the Red State Option, the persuasive narrative must include not only favorable financial terms but additional key elements as well.[11] The most significant of these may be a face–saving provision, a concession from the federal government, a bargaining chip, a tangible reminder that on some essential level states, not the federal government, are ultimately calling the shots. As other authors have discussed, this sort of negotiation between federal and state authorities is an under–examined, new front of federalism.[12] The Medicaid expansion dynamic offers a particularly salient example of this process of negotiated federalism.[13]

Within the Medicaid expansion context, a prime case study of this federal–state interplay is the novel arrangement approved in Arkansas.[14] The deal that

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8 *Id.* at 27.

9 *Id.*

10 *See infra* notes 173–78 (discussing estimated costs and political reactions in the state of Georgia).

11 *See infra* Part IV (outlining the Red State Narrative).

12 *See, e.g.*, Samuel R. Bagenstos, *Federalism by Waiver After the Health Care Case*, *in* The Health Care Case: The Supreme Court's Decision and Its Implications 6–7 (Gillian Metzger et al. eds., 2013), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2161599 (suggesting that *NFIB* gives states additional bargaining power by allowing them to credibly challenge the constitutionality of underlying spending clause legislation); Charlton C. Copeland, *Beyond Separation in Federalism Enforcement: Medicaid Expansion, Coercion, and the Norm of Engagement*, 15 U. Pa. J. Const. L. 91, 103–04 (2012) (urging a view of federalism that considers federal–state interactions during the policy implementation phase, not just as a matter of the legislative process); Abbe R. Gluck, Essay, *Instrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 Yale L.J. 534, 543 (2011) (refining traditional theories of statutory interpretation by emphasizing the role of states as implementers of federal law); Gillian E. Metzger, *Federalism Under Obama*, 53 Wm. & Mary L. Rev. 567, 569 (2011) ("[T]he central dynamic evident under the Obama administration to date is more active government . . . . States are given significant room to shape their participation in the new federal initiatives, as well as enhanced regulatory authority and expanded resources to do so."); Erin Ryan, *Negotiating Federalism*, 52 B.C. L. Rev. 1, 1 (2011) ("Bridging the fields of federalism and negotiation theory, *Negotiating Federalism* analyzes how public actors navigate difficult federalism terrain by negotiating directly with counterparts across state–federal lines.").

13 Ryan, *supra* note 12, at 4–5 ("[T]he Medicaid program represents a site of extensive negotiation between state and federal actors about the specifics of each state plan.").

14 *See* Sam Baker, *Feds Approve High–Profile ObamaCare Medicaid Waiver*, The Hill (Sept. 27, 2013), http://thehill.com/blogs/healthwatch/health–reform–implementation/325123–feds–approve–

Arkansas sought, and that the federal government approved, was to extend Medicaid to the ACA's expansion population using the same generous federal funding. But the Arkansas proposal will accomplish the expansion not through traditional Medicaid but by enrolling the additional beneficiaries in private plans sold through the ACA's newly established health insurance exchanges.[15] This arrangement accords Arkansas the benefit of federal financial support without compromising the Red State rhetoric that favors private market solutions to social problems and opposes expansion of government programs, particularly welfare programs.[16]

This Article examines the rhetoric and the reality behind the Red State Option, proposing a narrative that should compel expansion in states that opted out during this first legislative session.[17] The goal herein is to chart a path through the resistance that allows Red States to both take advantage of the federal government's extremely generous financial offer while saving face among stalwart Obamacare opponents and states' rights proponents. In addition to the Arkansas example, case studies of negotiated federalism in Michigan, Arizona, and Florida will be considered to illuminate the proposed Red State Narrative.

The Article proceeds in Part II with a brief description of the *NFIB v. Sebelius* decision on Medicaid. Part III provides background on the Medicaid program, highlighting the factual fallacies animating the Court's decision. Part IV describes the negotiated federalism landscape underlying Medicaid expansion, including arguments for and against its expansion as well as the case studies mentioned above. Part V concludes by outlining the Red State Narrative.

I. *NFIB v. Sebelius*: Creating the Red State Option

The Supreme Court's *NFIB v. Sebelius* opinion was surprising in several regards.[18] Many ACA opponents were surprised that the Court upheld the constitutionality of the individual mandate and even more surprised that the Roberts opinion relied on the taxing power to support its conclusion.[19] At

high–profile–waiver–for–obamacare–medicaid–expansion; Steven Ross Johnson, *Reform Update: CMS' Approval of Ark. Medicaid Expansion Plan Bodes Well for Other States*, Modern Healthcare (Oct. 1, 2013), http://www.modernhealthcare.com/article/20131001/NEWS/310019963.

15 Sara Rosenbaum & Benjamin D. Sommers, *Using Medicaid to Buy Private Health Insurance – The Great New Experiment?*, 369 New Eng. J. Med. 7, 7 (2013) [hereinafter Rosenbaum & Sommers, *The Great New Experiment*]; *see infra* Part III.C.2 (discussing the Arkansas plan).

16 *See* Baker, *supra* note 14 ("Arkansas Gov. Mike Beebe, a Democrat leading a deeply conservative state, crafted the option as a way to expand healthcare coverage without fully signing on to an expanded government program.").

17 *See infra* Part IV (outlining five key elements of the Red State Narrative).

18 *See* Huberfeld et al., *supra* note 6, at 36; *see also* Charles Fried, *The June Surprises: Balls, Strikes, and the Fog of War*, 38 J. Health Pol. Pol'y & L. 225 (2012).

19 NFIB v. Sebelius, 132 S. Ct. 2566, 2601 (2012); *see, e.g.*, Randy E. Barnett, *The Disdain Campaign,* 126 Harv. L. Rev. F. 1, 10 (2012) ("To 'save' the rest of Obamacare, the Chief Justice essen-

the same time, ACA supporters were unsettled by the Court's extended, and arguably unnecessary, discussion of the Commerce Clause, which concluded that the individual mandate exceeded Congress's power to regulate interstate commerce.[20] But most surprising of all was the Court's holding that mandatory expansion of Medicaid violated the spending power and could stand only if expansion were made optional, with no threat to states' existing federal Medicaid dollars if they opted out.[21]

The *NFIB* Medicaid decision was unprecedented as a matter of federalism jurisprudence. No Supreme Court decision since 1937 had struck down a federal spending power program.[22] No prior decision had actually held that a federal program was unconstitutionally coercive, despite suggestions in two earlier cases that such a limit on federal power might exist.[23] No lower court rulings in the *Health Care Cases* had held the ACA's Medicaid expansion unconstitutional. Accordingly, lower courts' opinions, as well as litigants' and amici's briefs, had given little consideration to the question of remedy should the Medicaid challenge succeed. By contrast, there was ample discussion of the effect of a ruling that the individual mandate was unconstitutional.[24]

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tially deleted the 'requirement' part. So the *mandate* qua mandate is gone. What is left is a tax."); David Bernstein, *Is This 1936?*, SCOTUSBlog (June 29, 2012, 9:32 AM), http://www.scotusblog.com/2012/06/is–this–1936/ ("Like the other Justice [Owen] Roberts in . . . 1936, the current Justice Roberts unexpectedly voted with a 5–4 majority to continue the old regime."); Ilya Somin, *A Taxing, but Potentially Hopeful Decision,* SCOTUSBlog (June 28, 2012, 6:13 PM), http://www.scotusblog.com/2012/06/a–taxing–but–potentially–hopeful–decision/ ("The ruling also runs counter to repeated statements by President Obama and numerous congressional Democrats, who assured us that the mandate was not a tax.").

20 *NFIB*, 132 S. Ct. at 2585–91; *see, e.g.*, Pamela S. Karlan, *Foreword: Democracy and Disdain*, 126 Harv. L. Rev. 1, 47 (2012) (calling Chief Justice Roberts's opinion "probably the most grudging opinion ever to uphold a major piece of legislation"); Gregory P. Magarian, *Chief Justice Roberts's Individual Mandate: The Lawless Medicine of* NFIB v. Sebelius, 108 Nw. U. L. Rev. Colloquy 15, 19 (2013) ("The Chief Justice's analysis of the commerce power and the Necessary and Proper Clause announces no legal holding of the Court. No other Justice joined or concurred in this portion of his opinion; it represents the Chief Justice's solitary view. Why did the four joint dissenters, who echo the Chief Justice's restrictive federal power analysis, decline even to concur in his judgment? Presumably because this part of the Chief Justice's opinion announces no judgment in which to concur."); David A. Strauss, *Commerce Clause Revisionism and the Affordable Care Act*, 2012 Sup. Ct. Rev. 1, 26 ("*NFIB* was a remarkable decision, and not in a good way. Five Justices were willing to conclude that an important Act of Congress exceeded Congress's power under the Commerce Clause, and to reach that conclusion on the basis of reasoning that, if I am right, was very weak.").

21 *See NFIB*, 132 S. Ct. at 2608.

22 *See id.* at 2630 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part) (alteration in original) ("The Chief Justice therefore—*for the first time ever*—finds an exercise of Congress' spending power unconstitutionally coercive.").

23 *See* Steward Mach. Co. v. Davis, 301 U.S. 548, 585–93 (1937) (upholding unemployment compensation provisions of Social Security Act of 1935); South Dakota v. Dole, 483 U.S. 203, 212 (1987) (upholding state drinking age condition on federal highway funding).

24 *See, e.g.*, Florida *ex rel.* Bondi v. Dep't of Health and Human Servs., 780 F. Supp. 2d 1307 (N.D. Fla. 2011) (Vinson, J.) (holding that the individual mandate was unconstitutional and the provision was not severable, thereby striking down the entire law), *aff'd in part, rev'd in part sub nom.*

With little guidance from litigants or judges, the Court was left to craft its own remedy for its declaration that Medicaid expansion could not stand as written in the ACA. The Court's Medicaid decision, for all its surprises, was relatively restrained. To be clear, no provision of the ACA itself was struck down or ruled unconstitutional. Rather, the Court simply held that an existing, long–standing penalty available to the Secretary of Health and Human Services (HHS) could not apply to states that chose not to extend Medicaid benefits to the ACA expansion population.[25] Since its enactment, the Medicaid statute gave the Secretary authority to withhold all federal dollars from a state that failed to comply with statutory requirements of the program.[26] The Secretary, however, has never actually invoked that penalty, preferring to negotiate remedial measures with noncompliant states and maintain coverage for beneficiaries to the extent possible.[27]

Because the ACA seemed to require states to expand their Medicaid programs as a mandatory condition to continued program participation, the total withholding of funds penalty would seem to be available.[28] That possibility,

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Florida *ex rel.* Attorney Gen. v. Dep't of Health and Human Servs., 648 F.3d 1235 (11th Cir. 2011) (finding the individual mandate constitutional but severable, such that the rest of the law remained intact), *aff'd in part, rev'd in part sub nom.* NFIB v. Sebelius, 132 S. Ct. 2566 (2012); Mead v. Holder, 766 F. Supp. 2d 16 (D.D.C. 2011) (holding that the individual mandate did not violate the Commerce Clause or the Religious Freedom Restoration Act), *aff'd sub nom.* Seven–Sky v. Holder, 661 F.3d 1 (D.C. Cir. 2011), *cert. denied*, 133 S. Ct. 63 (2012) *and abrogated by* NFIB v. Sebelius, 132 S. Ct. 2566 (2012); Virginia *ex rel.* Cuccinelli v. Sebelius, 728 F. Supp. 2d 768 (E.D. Va. 2010) (holding that the individual mandate was unconstitutional in light of Virginia's recently enacted law purporting to nullify the mandate), *vacated*, 656 F.3d 253 (4th Cir. 2011) (dismissing since State lacked standing to challenge the individual mandate), *cert. denied*, 133 S. Ct. 59 (2012). *See also* Liberty Univ., Inc. v. Geithner, 753 F. Supp. 2d 611 (W.D. Va. 2010) (upholding individual mandate as constitutional), *vacated*, 671 F.3d 391 (4th Cir. 2011), *abrogated by* NFIB v. Sebelius, 132 S. Ct. 2566, 183 L. Ed. 2d 450 (2012); Thomas More Ctr. v. Obama, 720 F. Supp. 2d 882 (E.D. Mich. 2010) (finding the individual mandate constitutional under the Commerce Clause), *aff'd*, 651 F.3d 529 (6th Cir. 2011), *abrogated by* NFIB v. Sebelius, 132 S. Ct. 2566 (2012).

25 *NFIB*, 132 S. Ct. at 2607 (plurality opinion) ("What Congress is not free to do is penalize States that choose not to participate in that new program by taking away their existing Medicaid funding.").

26 Social Security Amendments of 1965, Pub. L. 89–97, § 121(a), 79 Stat. 286, 351 (codified as amended at 42 U.S.C. § 1396c (2012)).

27 Huberfeld et al., *supra* note 6, at 17 ("Not once in the nearly fifty–year history of the [Medicaid] program has the federal government withdrawn all federal funding from a noncompliant state."); *see* Bagenstos, *supra* note 12, at 5 (citing Edward A. Tomlinson & Jerry L. Mashaw, *The Enforcement of Federal Standards in Grant–in–Aid Programs: Suggestions for Beneficiary Involvement*, 58 Va. L. Rev. 600, 620 (1972)) ("[F]ederal agencies virtually never cut off all funds to states that fail to comply with the terms of a given program, even though the relevant statute will often authorize such a sanction. Federal officials simply do not want to harm a program's beneficiaries by cutting off funds to a noncompliant state.").

28 *See* 42 U.S.C. § 1396c (2012) (giving the Health and Human Services (HHS) Secretary the ability, after appropriate notice and hearing procedures, to cease making payments to a state "until the Secretary is satisfied that there will no longer be any such failure to comply [with § 1396a(a)'s requirements]").

the Court said, could not stand.[29] Threatening a state's entire federal Medicaid matching dollars—money on which states have relied on for decades to provide health care to particularly needy individuals and money that represents a substantial portion of states' budgets—on compliance with the ACA's expansion provisions passed the point at which "pressure turns into compulsion."[30] It was "coercive," as suggested by two prior Supreme Court opinions, although those earlier decisions concluded that the challenged statutes at issue did not cross the unconstitutional line.[31]

To remedy the unconstitutionality, the Court adopted a narrow remedy, suggested by Justice Ginsburg and approved by Solicitor General Paul Clement, late in the extra innings of oral arguments.[32] The Court ruled that the ACA's expansion of Medicaid must be read not as mandatory, but as optional.[33] States must be free to opt out, with no threat to their existing federal Medicaid dollars, or opt in, thereby receiving the generous initial 100% federal funding and perpetual 90% federal funding for the new population of beneficiaries. Opt–in states would be subject to all Medicaid requirements, new and old, including the "lose–all" penalty for noncompliance with both pre–ACA and ACA–amended Medicaid requirements.[34]

Essential to the Court's ruling was the conclusion that the ACA fundamentally changed the nature of the existing Medicaid program, rendering it different in kind, not just degree.[35] What Congress could not do, without running awry of the coercion doctrine, was to condition states' funding under an existing federal program on compliance with a new, different federal program.[36] To reach the conclusion that the ACA operated as a "new" program, rather than simply an amendment to an existing program, Chief Justice Roberts noted three key differences between "old" and "new" Medicaid: a different population of eligible beneficiaries, a different package of benefits, and a different federal

29 *NFIB*, 132 S. Ct. at 2607 (plurality opinion) ("What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding. Section 1396c gives the Secretary of Health and Human Services the authority to do just that.").

30 *Id.* at 2634 (quoting Steward Mach., 301 U.S. 548 590 (1937)).

31 Huberfeld et al., *supra* note 6, at 3 (discussing *Steward Mach.*, 301 U.S. at 585–93, and South Dakota v. Dole, 483 U.S. 203, 212 (1987)).

32 *See id.* at 72 & n.469 (quoting oral argument transcript).

33 *NFIB*, 132 S. Ct. at 2607.

34 *Id.* ("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.").

35 *Id.* at 2605 ("The Medicaid expansion, however, accomplishes a shift in kind, not merely degree.").

36 *See id.* at 2605. *See generally* Huberfeld et al., *supra* note 6, at 21 ("The *NFIB* plurality fundamentally misunderstood th[e Medicaid program's] history, leading it to overemphasize discontinuities between the existing Medicaid program and the Medicaid expansion. The plurality artificially split Medicaid into two programs: old and new.").

funding scheme.[37] As the next Part explains, however, none of those aspects of the ACA amendments are fundamentally different from the historical operation of the Medicaid program over the past five decades. The Court, and subsequently ACA opponents, overplayed the apparent differences to support the Red State Option.

II. Medicaid Then and Now

To appreciate the underlying congressional design of ACA's Medicaid expansion and the unintended consequences of the Supreme Court's creation of the Red State Option in *NFIB v. Sebelius*, a brief background on the program is helpful. Where Congress, in the ACA, knitted together a near–complete safety net of insurance coverage for previously uninsured Americans, the Court, in *NFIB*, left a gaping hole through which a substantial number of low–income adults will be left without any assistance to obtain health insurance, at least in states that elect the Red State Option. By placing the ACA amendments in the context of the Medicaid program's history and evolution, this Part provides perspective on the terms of the arrangement that states are invited to accept. The first essential element of the Red State Narrative is the recognition that the ACA's Medicaid expansion is not so different in kind as the Court suggested.

A. Medicaid Expansion Under the ACA

The ACA, as a result of public preferences and political reality, did not radically overhaul the United States health care system. Single–payer health care was never even on the table, and the so–called "public option" received only nominal consideration.[38] Instead, the ACA builds on the United States' admittedly anachronistic, hybrid public–private health care system. The current system operates from the assumption that at least some individuals should not be left to fend for themselves in the private market for health care, but instead, should receive public assistance.

The ACA aims to expand private insurance coverage in both the dominant employer–based market and the underutilized individual health insurance market through a range of strategies. For large employers, the ACA implements default enrollment requirements, meaning that employees are automatically

37 *NFIB*, 132 S. Ct. at 2605–06.

38 *See generally* M. Gregg Bloche, *The Emergent Logic of Health Law*, 82 S. Cal. L. Rev. 389, 443 (2009) (discussing the possibility of single–payer or public option approaches); James Brasfield, *The Politics of Ideas: Where Did the Public Option Come from and Where Is it Going?*, 36 J. Health Pol. Pol'y & L. 455 (2011); Brendan S. Maher, *The Benefits of Opt–In Federalism*, 52 B.C. L. Rev. 1733, 1740–50 (2011) ("In America, the current political environment suggests no epic expansion of the [health care] benefit as entitlement approach is in the foreseeable future."); N. Gregory Mankiw, *The Pitfalls of the Public Option*, N.Y. Times, June 28, 2009, at BU5; Op–Ed., *The End of Private Health Insurance*, Wall St. J., Apr. 13, 2009, at A14.

enrolled in an employer–based plan and must actively opt out.[39] Large employers are also subject to limited penalties for failing to provide affordable health plans to employees.[40] With respect to small employers, the ACA offers generous tax credits to encourage them to offer health insurance to employees[41] and creates a new Small–Business Health Options Program (SHOP).[42]

The ACA's strategies to expand coverage in the private, individual health insurance market include the health insurance exchanges, the individual mandate, and insurance underwriting reforms. Without the advantage of large risk pools characteristic of employer group plans, individual health plans have long been more difficult and expensive to obtain.[43] The ACA aims to remedy noted dysfunctions in the individual market by prohibiting pre–existing condition exclusions[44] and discriminatory health status pricing.[45] The individual mandate, or minimum essential coverage provision,[46] and exchanges[47] support these reforms by expanding risk pools and equalizing insurer pricing.

The ACA also expands public assistance, specifically, Medicaid. Under the terms of the statute, all Americans earning below 133% of the federal poverty level (FPL) are eligible for Medicaid.[48] This approach to Medicaid expansion won out over other proposals, including: the House Leadership bill, which would have raised Medicaid eligibility to 150% FPL,[49] a public option,[50] and full reliance on tax subsidies for uninsured individuals to purchase private health

39 Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111–148, § 1151, 124 Stat. 119, 252 (2010) (codified as 29 U.S.C. § 218A (2012) (mandating that automatic enrollment is applicable to employers with more than 200 full–time employees).

40 PPACA § 1401 (codified as amended at I.R.C. § 36B (2012)); PPACA § 1513 (codified as amended at I.R.C. § 2980H (2012)). Effective in 2015 the amendment is applicable to employers with 51 or more full–time equivalent employees.

41 I.R.C. § 45R(g) (2012). A small employer is defined as an employer with "no more than 25 full–time equivalent employees for the taxable year." I.R.C. § 45R(d)(1).

42 42 U.S.C. § 18031(b)(1)(B) (2012).

43 *See* Amy B. Monahan, *Health Insurance Risk Pooling and Social Solidarity: A Response to Professor David Hyman*, 14 Conn. Ins. L.J. 325, 327–28 (2008); Allison K. Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 Am. J.L. & Med. 7, 51–53 (2010).

44 42 U.S.C. § 300gg–3 (2012).

45 42 U.S.C. § 300gg(a).

46 I.R.C. § 5000A (2012).

47 42 U.S.C. § 18031 (2012).

48 Under the ACA, a family of four with an annual income of roughly $31,000 would be below 133% FPL and thus eligible for Medicaid. PPACA, Pub. L. No. 111–148, § 2001(a)(1), 124 Stat. 119, 271 (2010) (codified at 42 U.S.C. § 1396a (2012)).

49 John Holahan, Kaiser Comm'n on Medicaid & the Uninsured, The Henry J. Kaiser Family Found., Alternatives for Financing Medicaid Expansions in Health Reform 1 (Dec, 2009), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8029.pdf.

50 Robert Pear & Jackie Calmes, *Senators Reject Pair of Public Option Proposals*, N.Y. Times (Sept. 29, 2009), at A18, http://www.nytimes.com/2009/09/30/health/policy/30health.html.

insurance.[51] The policy compromise struck in the ACA is that impoverished Americans will be provided government health insurance through Medicaid while low–income individuals will be required to purchase health insurance in the private market, with some federal financial assistance through premium assistance tax credits.[52]

At the time of the ACA's enactment, Medicaid covered sixty million Americans.[53] By 2020, 25% of the U.S. population was expected to be covered by Medicaid.[54] Following the *NFIB* decision, the Congressional Budget Office adjusted prior projections, estimating that six million fewer people would be newly enrolled in Medicaid and the Children's Health Insurance Program (CHIP) as a result of states opting out.[55] For many of these now excluded individuals and families, there is no other affordable coverage.

B. Medicaid Primer

Medicaid is a long–standing strategy for providing health insurance coverage to the "deserving" poor.[56] Traditionally, the deserving poor have included women, particularly widows, and their children, the blind, the disabled, and the impoverished elderly.[57] The prevailing belief was that the working poor

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51 *See* Sara Rosenbaum & Benjamin D. Sommers, *Rethinking Medicaid in the New Normal*, 5 St. Louis U. J. Health L. & Pol'y 127, 130 n.18 (2011) (suggesting that the proposal to cover all low–income adults through the exchanges was rejected because the federal government would have assumed the full cost, as compared to Medicaid, under which states and the federal government share the cost); Leighton Ku & Matthew Broaddus, *Public And Private Health Insurance: Stacking up the Costs*, 27 Health Aff. w318, w326 (2008), http://content.healthaffairs.org/content/27/4/w318.full.pdf; Leighton Ku, *Expanding Coverage for Low–Income Americans: Medicaid or Health Insurance Exchanges?*, Health Aff. Blog (June 23, 2009), http://healthaffairs.org/blog/2009/06/23/expanding–coverage–for–low–income–americans–medicaid–of–health–insurance–exchanges/.

52 *See* I.R.C. § 36B (20122011) (providing for premium assistance tax credits for purchase of qualified health plans).

53 Elizabeth Weeks Leonard, *Rhetorical Federalism: The Value of State–Based Dissent to Federal Health Reform*, 39 Hofstra L. Rev. 111, 136 (2010) [hereinafter Leonard, *Rhetorical Federalism*]; *see also* Sara Rosenbaum, *A "Customary and Necessary" Program – Medicaid and Health Reform*, 362 New Eng. J. Med. 1952, 1952 (2010).

54 Leonard, *Rhetorical Federalism*, *supra* note 53, at 136.

55 Cong.Budget Office, Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision 8 (July 2012), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472–07–24–2012–CoverageEstimates.pdf [hereinafter CBO, July 2012].

56 *See* Sara Rosenbaum et al., *Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP*, 1 J. Health & Biomed. L. 1, 7–8 (2004) ("Medicaid is the largest surviving public means–tested legal entitlement.").

57 Timothy Stoltzfus Jost, Disentitlement? The Threats Facing Our Public Health–Care Programs and a Rights–Based Response 80 (2003) (listing the beneficiaries of state and federal public assistance programs); Robert Stevens & Rosemary Stevens, Welfare Medicine in America: A Case Study of Medicaid 6–7 (1974) (identifying targets of special assistance programs during the early twentieth century); Nicole Huberfeld, *Federalizing Medicaid*, 14

deserved assistance, while the non–working poor, or paupers, did not.[58] Before the New Deal, federal funding for health care was largely limited to public health objectives, including infectious disease control, which focused on the immigrant population, as well as limited assistance to pregnant women, infants, and disabled children.[59]

1. Origins of Medicaid.—The Social Security Act of 1935 (SSA) provides the statutory basis for both Medicare and Medicaid, although those two signature health insurance programs would not be enacted for another thirty years.[60] As part of President Franklin D. Roosevelt's New Deal legislation, the SSA effectively codified the historical categories of deserving poor—the elderly, children, widows and widowers, blind, disabled, and unemployed—deeming them eligible for government assistance through income security.[61] With the exception of limited, open–ended federal grants to states,[62] the framers of the 1935 SSA put the goal of government health insurance aside due to political objections, including widespread fear of socialized medicine and tenuous political support for the SSA itself.[63] Health care would not be added to the SSA until President Lyndon B. Johnson's 1965 War on Poverty.[64]

In 1965, Congress enacted comprehensive, federal health insurance benefits for the elderly. The new Medicare program included Part A, covering inpatient hospital care, and Part B, covering outpatient and physician services.[65] Medicaid was something of an afterthought in the 1965 amendments.[66] Unlike Medicare, which operates as a type of public pension, available to all elderly Americans regardless of income, Congress intended Medicaid as a means–tested welfare program.[67] Medicaid would provide health care to the needy,

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U. Pa. J. Const. L. 431, 439 (2011) [hereinafter Huberfeld, *Federalizing Medicaid*].

58 *See* Stevens & Stevens, *supra* note 57, at 11 (describing the clear division between contributing work–related social insurance to workers and giving to the "poor").

59 *See* Lawrence O. Gostin, Public Health Law: Power, Duty, Restraint 155–56, 159–60 (2d ed. 2008); Paul Starr, The Social Transformation of American Medicine 240–42 (1982); Elizabeth Fee & Theodore M. Brown, *The Unfulfilled Promise of Public Health: Déjà Vu All Over Again*, 21 Health Aff., no. 6, 2002, at 31, 34–35.

60 Huberfeld, *Federalizing Medicaid*, *supra* note 57, at 441; Elizabeth A. Weeks, *Cooperative Federalism and Healthcare Reform: The Medicare Part D "Clawback" Example*, 1 St. Louis U. J. Health L. & Pol'y 79, 83–84 (2007) [hereinafter Weeks, *Cooperative Federalism*].

61 Huberfeld, *Federalizing Medicaid*, *supra* note 57, at 441.

62 *See* Starr, *supra* note 59, at 270; Huberfeld, *Federalizing Medicaid*, *supra* note 57, at 442 & n.47.

63 *See* Starr, *supra* note 59, at 266–69; Robert I. Field, *Regulation, Reform and the Creation of Free Market Health Care*, 32 Hamline J. Pub. L. & Pol'y 301, 308 (2011).

64 *See* Starr, *supra* note 59, at 369.

65 Weeks, *Cooperative Federalism*, *supra* note 60, at 83.

66 *See* Stevens & Stevens, *supra* note 57, at 51 (describing Medicaid as "ill–designed" compared to Medicare).

67 *See* Starr, *supra* note 59, at 368–70.

including individuals impoverished by staggeringly high medical expenses.[68] Unlike prior federal conditional spending programs, which operated as limited grants–in–aid to states, Medicaid was created and continues to offer open–ended federal funding to the states so long as they comply with broad federal requirements under the Medicaid Act.[69] Medicaid was well received by the states, as evidenced by the vast majority electing to participate in the program within a few years of its enactment.[70]

2. Medicaid Coverage.—At its enactment, Medicaid targeted the now–familiar categories of deserving poor who were elsewise eligible for assistance under existing government programs.[71] The original groups entitled to Medicaid on a mandatory basis were elderly and disabled persons receiving welfare under federal cash assistance programs, and dependent children and their caretaker relatives receiving Aid to Families with Dependent Children (AFDC).[72] Congress later replaced the cash assistance programs for the disabled adults, dependent children, and impoverished elderly with Supplemental Security Income (SSI). These groups continued to qualify for Medicaid on the basis of SSI eligibility.[73] Additionally, Congress later replaced AFDC with Temporary Assistance for Needy Families (TANF) but retained the historical AFDC eligibility category for Medicaid.[74]

The Medicaid Act established varying eligibility poverty thresholds for the above–listed welfare categories. But once applicants meet the income and categorical eligibility requirements, they are eligible for a defined medical assistance package[75] characterized by uniform, statewide benefits,[76] and open selection of healthcare providers.[77] By design, Medicaid "mainstreams"

68 *See* Schweiker v. Gray Panthers, 453 U.S. 34, 36–37 (1981) (describing enactment of Medicaid program); Brogan v. Miller, 537 F. Supp. 139, 142 (N.D. Ill. 1982); Rosenbaum et al., *supra* note 56, 7–8 (characterizing Medicaid as "an 'afterthought' to Medicare, and a 'relegation' to states of responsibility for insuring the poor").

69 Efforts to metamorphose Medicaid into a capped block grant have failed. *See, e.g.*, Jeanne M. Lambrew, *Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals*, 83 Milbank Q. 41, 46–47 (2005) (outlining the efforts of Newt Gingrich and George Bush to make a capped block grant part of federal Medicaid funding).

70 *See* Huberfeld, *Federalizing Medicaid*, *supra* note 57, at 445 & n.69 (noting that the holdouts, Arizona and Alaska, joined Medicaid in 1982 and 1972, respectively).

71 *Id.* at 445–46.

72 Sara Rosenbaum et. al., Law and the American Health Care System 503 (2d ed. 2012).

73 *Id.* at 503.

74 *Id.* at 503 & n.*.

75 42 U.S.C. § 1396a(a)(8), (10)(B) (2012) (mandating that medical assistance for Medicaid enrollees be equal in amount, scope, and duration to the assistance given to any other individual).

76 42 U.S.C. § 1396a(a)(1) (providing that a state medical assistance plan must "be in effect in all political subdivisions of the State").

77 42 U.S.C. § 1396a(a)(23) (2006) (current version at 42 U.S.C. § 1396a(a)(23) (2012)) (allowing Medicaid enrollees to choose their own practitioners and medical facilities).

beneficiaries, ensuring access to the same hospitals, physicians, and other health care providers as privately insured patients, rather than relegating them to public wards or clinics.[78] Medicaid has no pre–existing condition exclusions and no waiting periods.[79] While health care providers are not required to participate in the Medicaid program, states are required to provide reimbursement adequate to ensure sufficient provider participation.[80] States that elect to participate in Medicaid have considerable discretion over eligibility requirements and program benefits.[81] The federal Medicaid statute requires states to cover certain beneficiaries and services, but states can expand eligibility and services beyond those mandatory groups and services.[82] As long as states comply with the broad federal requirements, they receive open–ended federal matching dollars to support their state Medicaid programs.[83] If the Secretary of HHS, after providing reasonable notice and opportunity for hearing to the state Medicaid agency, determines that a state plan has fallen out of compliance or substantially fails to comply with federal Medicaid requirements, the Secretary has limited discretion to withhold federal funding related to the noncompliance until the plan is corrected.[84]

C. Different in Degree, But Not in Kind

Over the life of the Medicaid program, Congress has repeatedly amended and expanded the program in various respects.[85] As Sara Rosenbaum noted, "[t]hese expansions read like a litany of social problems."[86] Expansion of Medicaid to address national problems has been a hallmark of the program since its

78 Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post–Deficit Reduction Act Era*, 9 J. Health Care L. & Pol'y 5, 9 (2006) [hereinafter Rosenbaum, *Medicaid at Forty*].

79 Rosenbaum, *Medicaid at Forty*, *supra* note 78, at 12; *see* 42 U.S.C. § 1396a(a)(34).

80 § 1396a(a)(30)(A).

81 *See* Schweiker v. Gray Panthers, 453 U.S. 34, 37 (1981) (describing "categorically" and "medically" needy beneficiaries); Copeland, *supra* note 12, at 134 ("Medicaid's structure allows states considerable discretion in the design of state programs."); Eleanor D. Kinney, *Rule and Policy Making for the Medicaid Program: A Challenge to Federalism*, 51 Ohio St. L.J. 855, 857 (1990) ("[B]ecause states have great flexibility . . . the Medicaid program is really 50 very different programs serving different populations and providing different benefits."); Rosenbaum, *Medicaid at Forty*, *supra* note 78, at 12–13 (describing Medicaid eligibility and coverage); Weeks, *Cooperative Federalism*, *supra* note 60, at 83–84.

82 42 U.S.C. § 1396a(a)(10)(A)(i)–(ii) (2012). Additional services also can receive matching funds. *See* 42 U.S.C. § 1396d(a) (2012) (defining services that qualify as "medical assistance" and therefore receive funding).

83 *See* 42 U.S.C. § 1396b (2012) (addressing how the federal government makes payments to states).

84 42 U.S.C. § 1396c (2012).

85 Rosenbaum, *Medicaid at Forty*, *supra* note 78, at 18–19.

86 *Id.* at 16.

inception.[87] In light of this history, the Supreme Court's conclusion—that the ACA amendments fundamentally altered the nature of the Medicaid program, creating a "new" program and conditioning state funding to an unprecedented and unconstitutional extent—is clearly wrong. The eligibility, coverage, and funding provisions are consistent with the program's history and well within the scope of Congress's statutory authority. These points bear emphasis in crafting the Red State Narrative, clarifying that what the ACA asks of states is not as dramatically different or as threatening to states' rights as opponents would suggest.

1. Prior Eligibility Challenges.—In 1965, when Medicaid was enacted, there was no question that children were among the deserving poor. Consistent with that policy, Medicaid was soon expanded to address nationwide concerns regarding children's health, including rampant poor health among preschool children and high failure rates by young draftees on Army physical exams.[88] In response, Congress enacted a suite of reforms in 1967 including, strengthening the education and training of pediatric health professionals. The 1967 amendments also provided direct financing to state and local public health departments to identify, screen, and treat impoverished children and youth.[89]

Reflecting a change in traditional eligibility categories under federal law, Congress expanded Medicaid coverage just a few years later. In 1972, Congress ended the federal–state cooperative welfare program for the aged, blind, and disabled replacing it with federal Supplemental Security Income (SSI).[90] Congress revised Medicaid to reflect this new national policy and required states to either extend Medicaid to all individuals eligible for the new SSI program or, under the so–called 209(b) option, allow those individuals with incomes above the prior program's eligibility limits to qualify for Medicaid by deducting medical expenses from income.[91] Although the 1972 amendments allowed States two options in order to comply with the new national policy, states did not have the option to forgo Medicaid expansion entirely.[92]

87 *See* Sidney D. Watson, *The View from the Bottom: Consumer–Directed Medicaid and Cost–Shifting to Patients*, 51 St. Louis U. L.J. 403, 405 (2007); *see* Sara Rosenbaum, *Medicaid*, 346 New Eng. J. Med. 635, 635 (2002).

88 Sara Rosenbaum et al., *National Security and U.S. Child Health Policy: The Origins and Continuing Role of Medicaid and EPSDT* 6–11 (2005), *available at* http://sphhs.gwu.edu/departments/healthpolicy/CHPR/downloads/mil_prep042605.pdf.

89 Social Security Act Amendments of 1967, Pub. L. No. 90–248, § 301, 81 Stat. 821, 921–28 (codified as amended at 42 U.S.C. §§ 701–731 (2012)).

90 Social Security Act Amendments of 1972, Pub. L. No. 92–603, §§ 201, 301, 86 Stat. 1329, 1370, 1465 (codified as amended in scattered sections of 42 U.S.C.).

91 § 209, 86 Stat. 1329, 1381–82; § 301, 86 Stat. 1329, 1465 .

92 Act of July 9, 1973, Pub. L. No. 93–66, § 212, 87 Stat. 152, 155–58 (defining mandatory SSI coverage).

In 1988, Congress went even further and completely delinked Medicaid eligibility for children and pregnant women from federal–state cooperative welfare programs. Instead, Congress created across–the–board, mandatory eligibility categories up to 133% FPL for children from birth to age five and for pregnant women, and up to 100% FPL for children ages six to eighteen.[93] Again, Congress did not offer states any choice about extending coverage, other than leaving Medicaid entirely.[94]

Like these prior changes, the ACA expands Medicaid by adding a new category of beneficiaries and lowering the income threshold for certain currently eligible groups. The ACA extends Medicaid eligibility to all children and adults under sixty–five with incomes up to 133% FPL who are not pregnant, eligible for Medicare, or otherwise eligible through another mandatory Medicaid category.[95] Under the ACA, income eligibility for Medicaid will be determined based on a modified adjusted gross income standard, which disregards the first 5% of the applicant's income, effectively raising the income level to 138%.[96] The ACA's Medicaid expansion is particularly significant for non–elderly, non–disabled, low–income single adults or couples without children because they previously would not have qualified for Medicaid, or would have qualified only to a limited extent in those few states that opted to cover them.

Chief Justice Roberts maintained that this coverage expansion under the ACA fundamentally transformed Medicaid, making it "no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage."[97] But that distinction is more a matter of semantics than substance. As Justice Ginsburg

93 *See* Medicare Catastrophic Coverage Act (MCCA) of 1988, Pub. L. 100–360, § 302, 102 Stat. 683, 750–54 (adding 42 U.S.C. §§ 1396a(a)(A)(10)(i), 1396a(l) (2012)); Omnibus Budget Reconciliation Act of 1990, Pub. L. 101–508, § 4601, 104 Stat. 1388, 166–67 (codified as amended at 42 U.S.C. § 1396a (2012)).

94 *See* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101–239, §6401, 103 Stat. 2106, 2258–59 (amending 42 U.S.C. §§ 1396a(a)(10)(A)(i), 1396a(l) (2012)) (mandating eligibility for pregnant women and children under six up to 133% FPL); Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101–508, § 4601, 104 Stat. 1388, 166–67 (amending 42 U.S.C. §§ 1396a(a)(10)(A)(i), 1396a(),(l) (2012)) (setting eligibility for children between six and eighteen years of age at 100% FPL).

95 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012).

96 *See* PPACA, Pub. L. No. 111–148, § 1401, 124 Stat. 119, 217–18 (2010) (codified as amended at I.R.C. § 36 (2012)) (defining "modified adjusted gross income," or MAGI); Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 Fed. Reg. 17,144, 17,146 (Mar. 23, 2012) (to be codified at 42 C.F.R. § 435.119); *see also* Sara Rosenbaum, *A "Customary and Necessary" Program – Medicaid and Health Care* Reform, 36 New Eng. J. Med. 1952, 1953 (2010) (citing Congressional Budget Office estimates that new income calculation methods will effectively raise the threshold to 138% of the FPL); The Henry J. Kaiser Family Found., Determining Income for Adults Applying for Medicaid and Exchange Coverage Subsidies: How Income Measured With a Prior Tax Return Compares to Current Income at Enrollment 1 (Mar. 2011), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8168.pdf.

97 NFIB v. Sebelius, 132 S. Ct. 2566, 2606 (2012) (plurality opinion).

queried, surely a single adult earning under 138% FPL, or roughly $15,000 annually, is among the neediest among us.[98]

In sum, the established history of significant changes to and expansions of Medicaid eligibility demonstrate that the ACA's expansion to low–income, working–age adults was neither unprecedented nor different in kind. Congress has repeatedly added new beneficiaries to the Medicaid rolls, without giving states the option to decline coverage to the new population. Moreover, the Medicaid statute expressly authorizes Congress to amend the statute,[99] and the ACA's amendments did not cross any constitutionally significant line.

2. Prior Benefits Changes.—Chief Justice Roberts further suggested that the ACA's Medicaid amendments were different in kind because the expansion population would receive a different set of benefits from the current Medicaid population.[100] But this sort of change, too, is not unprecedented. Although a uniform package of benefits was one of Medicaid's hallmarks, Congress has amended these benefits over time to include variations for certain beneficiaries. The ACA does not represent a new federal–state program but merely follows a longstanding trend.

First, as part of the 1967 amendments expanding coverage for children under Medicaid, Congress dramatically expanded the Medicaid coverage requirements, creating the Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program.[101] EPSDT is a mandatory set of services and benefits for all individuals under the age of twenty–one who are enrolled in Medicaid.[102] EPSDT requires states to cover, at a minimum, comprehensive health and developmental history, physical exams, immunizations, laboratory tests, and health education as well as vision, dental, and hearing services.[103] States are also required to cover care needed to diagnose or treat any condition detected by the EPSDT screening, even if that treatment is not otherwise available under a state's Medicaid plan.[104] EPSDT expanded the mandatory

98 *Id.* at 2636 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part) ("Single adults earning no more than $14,856 per year—133% of the current federal poverty level—surely rank among the Nation's poor.").

99 42 U.S.C. § 1304 (2012) ("The right to alter, amend, or repeal any provision of [the Medicaid Act] is hereby reserved to the Congress.").

100 *NFIB*, 132 S. Ct. at 2605–06 (plurality opinion).

101 Social Security Act Amendments of 1967, Pub. L. No. 90–248, §§ 301–02, 81 Stat. 821, 921–29 (codified as amended at 42 U.S.C. §§ 701–31, 1396d (2012)) (implementing a major expansion of Medicaid coverage concerning the healthcare needs of children under twenty–one, including early screening and prevention measures to ensure continued health).

102 42 U.S.C. §§ 1396a(a)(43), 1396d(r) (2012); *see* Frew v. Hawkins, 540 U.S. 431, 433–34 (2004) (describing the EPSDT program).

103 42 U.S.C. § 1396d(r).

104 *See* § 1396d(r)(5) (defining EPSDT to include "[s]uch other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening

coverage standards for children to a level unequaled in public or private health insurance at the time.[105] Since 1967, Congress has strengthened EPSDT several times, often over political objections from some states.[106] Yet these provisions stand as constitutional exercise of federal power.

One of Congress's most significant modifications of Medicaid was to grant the Secretary of HHS the authority to issue waivers allowing states to vary from the requirements of the federal Medicaid Act.[107] Beginning in 1981, Congress authorized Section 1915(b) waivers to provide home and community–based services allowing individuals to avoid institutionalization.[108] Later Congress added Section 1115 waivers, which allow broad flexibility and state experimentation to cover the uninsured so long as states do not increase costs to the federal government.[109] Over the years, states have received Section 1115 waivers of varying scope and purpose while implementing unique Medicaid strategies.[110] The ACA affirms the availability of Section 1115 waivers, but

services, whether or not such services are covered under the State plan.").

105 *See* Sara Rosenbaum & Paul H. Wise, *Crossing the Medicaid–Private Insurance Divide: The Case of EPSDT*, 26 Health Aff. 382, 383–84 (2007).

106 *See* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101–239, § 6403, 103 Stat. 2106, 2262–63 (further delineating the scope of EPSDT benefit, including an express mandate that states cover "[s]uch other necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan"); Deficit Reduction Act of 2005, Pub. L. No. 109–171, § 6044(a), 120 Stat. 4, 88–89 (requires states to preserve EPSDT coverage in benchmark packages); Children's Health Insurance Program (CHIP) Reauthorization Act of 2009, Pub. L. No. 111–3, § 611, 123 Stat. 8, 100 (clarifying requirement to provide EPSDT in benchmark packages); PPACA, Pub. L. No. 111–148, § 2201, 124 Stat. 119, 289–91 (2010) (preserving EPSDT as part of the newly reconfigured benchmarks); *see also* Alice Sardell & Kay Johnson, *The Politics of EPSDT Policy in the 1990s: Policy Entrepreneurs, Political Streams, and Children's Health Benefits*, 76 Milbank Q. 175, 190–92, 197–98 (1998) (describing changes to EPSDT in light of state autonomy concerns).

107 *See* Copeland, *supra* note 12, at 133 (noting that recent administrations have "increasingly sought to expand state discretion by allowing states to apply for waivers to obtain relief from certain Medicaid requirements"); Ryan, *supra* note 12, at 62–64 (describing Medicaid "demonstration waivers" and other "program waivers").

108 *See* 42 C.F.R. § 441.300 (2012); Bagenstos, *supra* note 12, at 11 (describing waiver–based programs for community–based services to the elderly and disabled).

109 *See* Social Security Act, Pub. L. No. 74–271, § 1115, 49 Stat. 690 (codified as amended at 42 U.S.C. § 1315(a) (2012)) (giving the Secretary discretion to appropriate funds for experimental projects not otherwise covered); Elizabeth Weeks Leonard, *The Rhetoric Hits the Road: State Challenges to Affordable Care Act Implementation*, 46 U. Rich. L. Rev. 781, 790 (2012) (describing Section 1115 waivers).

110 *See Are Block Grants the Wave of the Future for Medicaid?*, State Health Watch, Sept. 2011, at 1, 2–3 (describing Tennessee and Oregon experiments); Cyril F. Chang, *Evolution of TennCare Yields Valuable Lessons*, Managed Care, Nov. 2007, at 45, 47; Daniel M. Fox & Howard M. Leichter, *State Model: Oregon: The Ups and Downs of Oregon's Rationing Plan*, 68 Health Aff., no. 2, 1993, at 66, 66–67, *available at* http://content.healthaffairs.org/content/12/2/66.full.pdf+html?sid=044ce5da–b798–42ac–b5a0–7940f171df59 (discussing Oregon's "Reform Demonstration" for waiving different Medicaid requirements); Peter D. Jacobson & Rebecca L. Braun, *Let*

provides additional administrative and congressional oversight.[111] The Balanced Budget Act of 1997 effectively operates as a blanket waiver, allowing states to implement Medicaid managed care through state plan amendments, rather than requiring them to request waivers.[112] The evolution of the Medicaid waiver process and other flexible options are part of a larger trend of federal–state negotiations over program design and implementation.[113] This precedent for negotiated federalism will be critical for crafting the Red State Narrative.[114]

Congress enacted another significant change to the Medicaid benefits package with the Deficit Reduction Act (DRA) of 2005.[115] Section 6044 of the DRA allows states to modify their state plans to provide "benchmark coverage."[116] Significantly, benchmark coverage means that states are no longer required to provide Medicaid's signature defined benefits package on an equal basis.[117]

1000 Flowers Wilt: The Futility of State–Level Health–Care Reform, 55 KAN. L. REV. 1173, 1185–86 (2007) (describing Massachusetts's 1996 Section 1115 waiver). For a complete list of current Section 1115 waivers, see *Waivers*, MEDICAID.GOV, http://www.medicaid.gov/Medicaid–CHIP–Program–Information/By–Topics/Waivers/Waivers.html (last visited Jan. 7, 2014).

111 PPACA, Pub. L. No. 111–148, § 2401, 124 Stat. 119, 297–301 (2010).

112 *See* 42 U.S.C. § 1396u–2(a) (2012) (allowing states to require Medicaid participants to enroll in managed care as long as the requirement meets certain conditions).

113 *See* Bagenstos, *supra* note 12, at 9–10 (suggesting among other merits of federalism by waiver, of which Medicaid is one example, that it "provides a mechanism for federal agencies to engage states before they depart from the strict requirements of funding statutes, to negotiate for provisions that preserve the key goals . . . and to do so in a context that preserves a measure of public accountability."); Ryan, *supra* note 12, at 58, 62–64 (describing Medicaid as an example of "policymaking laboratory negotiations").

114 *See infra* Part III (discussing negotiations between federal and state authorities post–NFIB); *see also* Copeland, *supra* note 12, at 136 ("Medicaid waivers involved significant 'bargaining' and negotiation between state and federal bureaucratic officials"); Ryan, *supra* note 12, at 63 ("[The Medicaid waiver] application process is extensively negotiated with the Department of Health and Human Services, with executive agents on both sides dickering back and forth over proposal terms before the application receives federal approval.").

115 Deficit Reduction Act of 2005, Pub. L. No. 109–171, § 6044(a), 120 Stat. 4, 88–92 (2006) (codified at 42 U.S.C. § 1396u–7 (2012)).

116 42 U.S.C. § 1396u–7(a)(1)(A) (2012) (giving states the option of providing only "benchmark benefits" to certain populations).

117 *Id.* "State flexibility in benefit packages," allows states to modify their plans:

> [A] State, at its option as a State plan amendment, may provide for medical assistance under this subchapter to individuals within one or more groups of individuals specified by the State through coverage that—
> (i) provides benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2); and
> (ii) for any individual described in section 1396d(a)(4)(B) of this title who is eligible under the State plan in accordance with paragraphs (10) and (17) of section 1396a(a) of this title, consists of the items and services described in section 1396d(a)(4)(B) of this title (relating to early and periodic screening, diagnostic, and treatment services defined in section 1396d(r) of this title) and provided in accordance with the requirements of section 1396a(a)(43) of this title.

Id.

Benchmark coverage, instead, permits states to enroll Medicaid beneficiaries in non–Medicaid managed care plans, which by statutory definition include the Federal Employee Health Benefit Program, state employee health benefit programs, any plan already offered by a major health maintenance organization in the state, or any other plan approved by the Secretary.[118] Benchmark coverage was intended to afford "[s]tates unprecedented flexibility within Medicaid State Plans to provide health benefits coverage."[119] States can require a large portion of the Medicaid population enroll in benchmark coverage and provide different benefits within eligibility categories, except with respect to some particularly vulnerable categories of enrollees, such as dual eligibles, terminally ill hospice patients, and women in cancer coverage programs.[120]

Under the DRA, states also have the option to provide "benchmark equivalent coverage."[121] Benchmark equivalent coverage is less comprehensive than Medicaid's traditional benefits package but nevertheless includes inpatient and outpatient hospital care, physician services, laboratory and x–ray services, and well–baby care and immunizations.[122] Those services must be supplied by an "actuarial equivalent" of the listed benchmark coverage providers.[123] Benchmark equivalent coverage essentially allows states to operate Medicaid as a defined contribution, rather than a defined benefits plan.[124] Instead of carefully planned, statutorily designed care and services, states can pay a private insurer who does not have to comply with the Medicaid Act.[125] The benchmark and benchmark–equivalent options effectively render Medicaid a "premium support" program that gives private insurers control over access to both benefits and providers, without attendant accountability.[126]

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118 § 1396u–7(b)(1).

119 Medicaid Program; State Flexibility for Medicaid Benefit Packages, 73 Fed. Reg. 9715, 9715 (proposed Feb. 22, 2008) (to be codified at 42 C.F.R. pt. 440).

120 42 U.S.C. § 1396u–7(a)(2)(B) (2012). Groups exempted from enrollment in a benchmark plan include pregnant women; blind and disabled individuals; dual eligibles; terminally ill individuals; people residing in hospitals, nursing facilities, intermediate care facilities for the mentally retarded, or other medical institutions; and individuals who are medically frail or have special needs. *See* 42 C.F.R. § 440.315 (2012) (including the following additional groups for exemption from enrollment in a benchmark plan: youth in foster care or receiving adoption assistance, youth with serious emotional disturbance, people with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and/or mental disabilities that significantly prevent them from performing one or more activities of daily living).

121 42 U.S.C. § 1396u–7(a)(1)(A), (b)(2) (2012).

122 § 1396u–7(b)(2)(A).

123 § 1396u–7(b)(2)(B)–(C). A qualified actuary must make the determination of actuarial equivalency, taking into account certain factors. § 1396u–7(b)(3).

124 *See* Jonathan Barry Forman, *Public Pensions: Choosing Between Defined Benefit and Defined Contribution Plans*, Mich. St. L. Rev. 187, 188 n.2 (1999).

125 *See* 42 U.S.C. § 1396u–7 (2012).

126 *See* Rosenbaum, *Medicaid at Forty*, *supra* note 78, at 41 ("A premium support approach . . . entitles individual to, at most, a defined contribution toward health coverage, with almost total discretion over actual benefit design left to insurer discretion rather than legally enforceable

For the newly eligible population under the ACA, states may provide the traditional Medicaid defined benefit package, but they are required only to provide benchmark or benchmark equivalent coverage[127] in accordance with the DRA definition.[128] The DRA exemptions for certain vulnerable beneficiaries continue to apply to the Medicaid expansion population under the ACA.[129] In other words, Chief Justice Roberts's conclusion in *NFIB*, that the ACA expansion population would have a "new" set of benefits is erroneous; the expansion population would receive either the traditional Medicaid benefits package or a DRA–consistent benchmark package, just like currently eligible enrollees.

The ACA does revise the DRA requirements in a few respects. These changes are applicable to all Medicaid beneficiaries under such plans, not just the ACA expansion population. First, benchmark and benchmark–equivalent benefits must include, at minimum, the package of "essential health benefits," as defined in the ACA. Accordingly, Medicaid beneficiaries covered under the DRA definition will receive the same package of benefits now required for individual and small group insurance plans sold inside and outside of the exchanges.[130] The ACA further specifies that benchmark or benchmark equivalent plans provide medical and surgical benefits, including treatment of mental health and substance abuse disorders, as well as comply with federal laws relating to mental health and substance abuse parity.[131] In addition, benchmark–equivalent packages now must cover prescription drugs and mental health services,[132] and both benchmark and benchmark–equivalent packages must cover family planning services and supplies.[133]

Despite those changes to the DRA's benchmark definition, the ACA's benefit package does not effect a constitutionally significant change to the existing Medicaid program. Variable coverage among Medicaid beneficiaries already exists, as seen with comparing children under EPSDT to adult enrollees and comparing states' benchmark plans to the traditional package of benefits. Moreover, Section 1115 waivers and other amendments have long allowed states to vary the coverage and employ private managed care plans to deliver benefits to Medicaid enrollees. The ACA's benefits package should not be viewed as different in kind.

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standards . . . .").").

127 42 U.S.C. §§ 1396a(k)(1), 1396u–7(b)(5), 18022(b) (2012).

128 42 C.F.R. §§ 440.330, 440.335 (defining benchmark coverage and benchmark equivalent coverage, respectively) (2012).

129 *See* 42 U.S.C. § 1396u–7(a)(2)(B) (2012); 42 C.F.R. § 440.315 (2012).

130 42 U.S.C. §§ 1396u–7(b)(5), 18022 (2012) (defining essential health benefits package).

131 42 U.S.C. § 1396u–7(b)(6)(A) (excluding those offered by Medicaid managed care organizations).

132 § 1396u–7(b)(2)(A).

133 § 1396u–7(b)(7).

3. Medicaid Funding Structure.—Chief Justice Roberts's third rationale for deeming the ACA amendments as "new" Medicaid concerned the funding structure. The ACA retains the essential cooperative federalism approach but shifts the weight of the financial obligation to the federal government. This change should make the program more, not less, consistent with states' traditional authority and discretion and, therefore, well within the federal spending power.

As the Supreme Court has previously noted, financial contribution by both the states and the federal government is the "cornerstone of Medicaid."[134] Through open–ended funding, states receive uncapped federal financial support for every state dollar spent. This arrangement incentivizes states to provide generous financial public benefits while the federal government shifts a portion of the funding burden to states.[135] Medicaid, however, is entirely voluntary.[136] States do not have to participate and could refuse federal dollars, choosing instead to either establish their own indigent health care programs or elect not to provide any medical assistance to low–income individuals.[137] All fifty states now accept federal funding to operate state Medicaid programs.[138]

As a condition of participation, states must submit a "state plan" to the federal agency.[139] The state plan explains how the state will comply with mandatory elements of Medicaid and identifies the optional elements that it may seek to utilize.[140] As noted above, states can also request waivers from some or all Medicaid requirements or operate their state Medicaid plans as managed care programs.[141] Once the state plan is in place and approved by federal authorities, states administer Medicaid with relatively little federal oversight.[142]

Each dollar a state spends on federally approved Medicaid programs, whether required or optional, is matched by federal funds on a percentage basis.[143] The federal match ranges from 50% to just over 73%, based on the amount of money the state spends on Medicaid and the state's per capita

134 Harris v. McRae, 448 U.S. 297, 308 (1980).

135 Leonard, *Rhetorical Federalism*, *supra* note 53, at 134–35.

136 *See Harris*, 448 U.S. at 301 ("Although participation in the Medicaid program is entirely optional, once a State elects to participate, it must comply with the requirements of [the Medicaid Act].").

137 *See* Kinney, *supra* note 81, at 857, 860.

138 Leonard, *Rhetorical Federalism*, *supra* note 53, at 135.

139 42 U.S.C. § 1396a(a) (2012) (defining compliance requirements necessary to create and run a State Plan).

140 *Id.*; Huberfeld, *Federalizing Medicaid*, *supra* note 57, at 447.

141 42 U.S.C. § 1396n (2012).

142 Huberfeld, *Federalizing Medicaid*, *supra* note 57, at 447.

143 *See* 42 U.S.C. § 1396b (2012)*; see also* Harris v. McRae, 448 U.S. 297, 308 (1980) (describing this system of matching state expenditures with federal funds as a "cooperative federalism" approach enacted "to provide federal financial assistance for all legitimate state expenditures under an approved Medicaid plan").

income.[144] In addition, states receive a federal match of at least 50% for the administrative costs of running the state Medicaid program.[145]

The ACA in no way alters the fundamental Medicaid funding arrangement. The only change is to place a much greater share of the funding onus on the federal government,[146] and that change is notably much more favorable to states. Compared to traditional federal Medicaid matching rates of 50% to just over 73%,[147] under the ACA the federal government will match state spending on newly eligible beneficiaries at no less than 90%.[148] For the first three years of Medicaid expansion, 2014 to 2016, the federal government will pay 100% of the cost of newly eligible beneficiaries in all states.[149] Thereafter, the federal percentage phases down gradually, from 95% in 2017, to 90% in 2020 and perpetually thereafter.[150] The more generous federal match only applies to the newly covered population.[151] States that previously expanded their Medicaid plans to cover any portion of the newly eligible population will also receive the enhanced match, meaning that those states may actually experience a savings as a result of the ACA's Medicaid expansion.[152] States are also eligible to receive an enhanced 90% match for some administrative costs associated with expansion.[153]

144 Federal Medicaid Assistance Percentage (FMAP) calculations are published in the Federal Register each year. *See* Federal Financial Participation in State Assistance Expenditures for Various Medicaid Programs 2013–2014, 77 Fed. Reg. 71,420 (Nov. 30, 2012), *available at* http://www.gpo.gov/fdsys/pkg/FR–2012–11–30/pdf/2012–29035.pdf.

145 *See* 42 U.S.C. § 1396b(a) (2012) (listing the percentage of the state spending the federal government will match depending on the type of expenditure) [hereinafter 2013–14 FMAP Calculations].

146 *See* John Holahan & Irene Headen, Kaiser Comm'n on Medicaid & the Uninsured, The Henry J. Kaiser Family Found., Medicaid Coverage and Spending in Health Reform: National and State–by–State Results for Adults at or Below 133% FPL 1, 2 (May 1, 2010), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/medicaid–coverage–and–spending–in–health–reform–national–and–state–by–state–results–for–adults–at–or–below–133–fpl.pdf (estimating that 95% of new spending will be by the federal government).

147 *See* 2013–14 FMAP Calculations, 77 Fed. Reg. at 71,420 (citing current FMAP).

148 42 U.S.C. § 1396d(y)(1) (2012). CHIP also has a very generous federal match, which helped to create the precedent for the ACA's enhanced match. *See* 42 U.S.C. § 1397ee(a)(1) (2012) (promising that the Secretary will pay the state an amount matching the amount of the FMAP for certain expenditures).

149 42 U.S.C. § 1397d(y)(1) (2012).

150 *Id.*

151 Huberfeld, *Federalizing Medicaid*, *supra* note 57, at 451.

152 *See* Holahan & Headen, *supra* note 146, at 4 (citing Massachusetts as one state that will experience savings under the Medicaid expansion).

153 U.S. Gov't Accountability Office, GAO–12–821, Medicaid Expansion: States' Implementation of the Patient Protection and Affordable Care Act 13–14 (2012), *available at* http://www.gao.gov/assets/600/593210.pdf; Centers for Medicare & Medicaid Servs., Dep't of Health & Human Servs., Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid 13 (Dec. 10, 2012), http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges–faqs–12–10–2012.pdf [hereinafter FAQ, Dec. 10, 2012] (affirming availability of 90% federal

Deeper discussion of the federalism implications of *NFIB* than this Article offers is necessary to fully assess the states' argument that more generous federal funding operates as unconstitutional coercion. But suffice to say that Chief Justice Roberts's reliance on the funding arrangement as evidence of a "shift in kind" is dubious. Just as Congress is free to amend the Medicaid statute to include additional beneficiaries and different packages of benefits, it is free to vary the financial terms. More importantly, the fact that the ACA does so in a way that is exceptionally favorable to states simply does not suggest any constitutional infirmity.

The Court's fundamental misappreciation of the history and operation of the Medicaid program, and mischaracterization of the effect of the ACA amendments on the program, resulted in a misguided decision. Because the Court concluded that the ACA creates a "new" program, on which states' "old" Medicaid dollars could not be conditioned, the solution was to treat Medicaid expansion as an option, rather than a mandatory requirement, for participating states.

The potential effect of this decision is that substantial portions of the anticipated new Medicaid population will be left out of the ACA's coverage plan.[154] Under the congressional design, currently uninsured adults below 138% FPL would become Medicaid eligible.[155] Currently uninsured adults between 100% and 400% FPL would be eligible for federal subsidies to purchase private health insurance on the exchanges.[156] Now, in opt–out states, uninsured adults below 100% FPL will be without both Medicaid coverage and federal assistance

matching funds for new eligibility systems that states develop to accommodate adjusted gross income calculations and coordinate with exchanges).

154 *See* Huberfeld et al., *supra* note 6, at 85–86 (discussing coverage gap); Benjamin D. Sommers & Arnold M. Epstein, *U.S. Governors and the Medicaid Expansion – No Quick Resolution in Sight*, 368 New Eng. J. Med. 496, 499 (Feb. 7, 2013), *available at* http://www.nejm.org/doi/full/10.1056/NEJMp1215785 (noting that, even with tax credits available to those above 100% FPL, "[the PPACA] will still leave millions of adults living below the poverty level without health insurance and without the means of acquiring it"); Robin Rudowitz & Jessica Stephens, Kaiser Comm'n on Medicaid & the Uninsured, The Henry J. Kaiser Family Found., Analyzing the Impact of State Medicaid Expansion Decisions 5, 6 fig.10 (July 17, 2013), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8458–analyzing–the–impact–of–state–medicaid–expansion–decisions2.pdf (estimating that over five million people would remain uninsured due to state decisions not to insure); *see also* Sally Tyler, *Opting for a Medicaid Donut Hole Makes State Budgets the Biggest Loser*, AFSCME Blog (Sept. 7, 2012), http://www.afscme.org/blog/opting–for–a–medicaid–donut–hole–makes–state–budgets–the–biggest–loser ("[I]n states that opt out, the Medicaid donut hole is born."); *Explaining the Coverage Gap*, Healthy Debate Georgia, http://healthyfuturega.org/archives/4531 (last visited Jan. 8, 2014) ("If Georgia fails to adopt this expansion, this would create a 'coverage gap,' leaving many Georgians with no options for affordable health coverage.").

155 *See supra* notes 95–96 and accompanying text.

156 *See* PPACA, Pub. L. No. 111–148, §§ 1401, 10105, 124 Stat. 119, 213, 906 (2010) (codified as amended at I.R.C. § 36B (2012)) (providing premium assistance tax credits for purchasing qualified health plans).

to purchase their own insurance.[157] The potential effect of this Medicaid "donut hole" has yet to be fully calculated, but state–by–state projections are staggering.[158]

III. Room for Negotiation

As crafted by the Court, Medicaid expansion under the ACA operates as a binary choice, an on–off switch, not a starting point for negotiations between individual states and the Secretary of HHS.[159] But as soon as the decision was announced, states approached the matter as just that: An invitation to strike a deal with the federal government.[160] To be sure, flexibility has become a common feature of the modern Medicaid program, with various options for states to negotiate, including Section 1115 and other waivers from otherwise applicable Medicaid requirements.[161] But neither the ACA nor *NFIB* expressly authorizes flexible implementation by states.

The Administration's initial position on Medicaid expansion post–*NFIB* suggested maximum flexibility.[162] There was no timeline for implementation; states could opt into or out of expansion at any time. By contrast, the ACA

157 Some states to cover childless adults up to a very low FPL. *See* Sommers & Epstein, *supra* note 154, at 499 ("[L]ow–income adults in at least a dozen states remain ineligible for any kind of public subsidy for health insurance."). *See generally* The Henry J. Kaiser Family Found., Adult Income Eligibility Limits at Application as a Percent of the Federal Poverty Level (FPL), January 2013, http://kff.org/medicaid/state–indicator/income–eligibility–low–income–adults/ (last visited Jan. 8, 2014) (reporting state–by–state coverage statistics).

158 *See* Rudowitz & Stephens, *supra* note 154, at 4 fig.5 (depicting coverage gap); *id.* at 6 fig.10 (estimating over five million people in opt–out states will fall in coverage gap).

159 *See* Ryan, *supra* note 12, at 4 (suggesting negotiated federalism as "offer[ing] a means of understanding the relationship between state and federal power that differs from the stylized model of zero–sum federalism dominating political discourse, which emphasizes winner–takes–all jurisdictional competition").

160 Letter from Dan Crippen, Nat'l Governors Ass'n, to Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs. (July 2, 2012), *available at* http://www.nga.org/cms/home/federal–relations/nga–letters/executive–committee–letters/col2–content/main–content–list/july–2–2012–letter——affordable.html (inquiring regarding partial Medicaid implementation, phased–in implementation, and other alternatives to expansion); Sommers & Epstein, *supra* note 154, at 499 (noting that several state governors petitioned HHS to allow partial expansions).

161 *See supra* notes 107–14 (discussing waiver and private managed care options under Medicaid); Copeland, *supra* note 12, at 135 ("Medicaid waivers have played a significant role in the transformation of Medicaid for nearly two decades."); Ryan, *supra* note 12, at 64 (listing various examples of states' Medicaid waivers).

162 Letter from Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs., to State Governors (July 10, 2012), *available at* http://capsules.kaiserhealthnews.org/wp–content/uploads/2012/07/Secretary–Sebelius–Letter–to–the–Governors–071012.pdf (emphasizing commitment "to providing states with as much flexibility as we can to achieve successful implementation" and emphasizing that the Supreme Court's Medicaid decision "did not affect other provisions of the law," including the fact "that states have flexibility to design the benefit package for individuals covered"); CBO, July 2012, *supra* note 55, at 8, 10 (noting that "final regulatory guidance is not yet available" regarding possible flexibility in expansion below 138% FPL, or to only specific subsets of

specifies particular implementation deadlines for states electing to establish state–based health insurance exchanges.[163] The Secretary of HHS at first seemed open to partial implementation with respect to the expansion population. States might be allowed to expand not all the way up to the statutory 138% FPL, or to vary income–level eligibility for different portions of the new population of beneficiaries. The Administration, however, later retreated from these suggestions, making it clear that opting–in states must include the entire expansion population up to the statutorily specified level.[164] Flexibility on the election date and free movement in and out of the program remain.[165] The Secretary also indicated that states would have flexibility regarding benchmark plans, different benefit packages for different populations, and cost–sharing requirements.[166]

In large part, the Administration has hewed the maximum flexibility line, in an apparent attempt to bring as many recalcitrant states on board as possible. The present high–water mark for flexibility is the Secretary's approval of Arkansas's plan to cover its entire Medicaid expansion population under private plans purchased on the new health insurance exchanges.[167] Arkansas was the start of a trend, with other Red States requesting similar deals or watching those developments closely before making their next moves.[168]

Under the Arkansas arrangement, the state would receive the ACA's generous federal funding at 100% for three years, followed by 90% perpetually, just like other expansion states.[169] But the federal dollars would go toward the cost of private plans to be sold on Arkansas's health insurance exchanges—the very same exchange plans that the rest of the individually insured population will be eligible to purchase under the ACA.[170] While the notion of Medicaid

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the expansion population and anticipating that "many states will try to work out arrangements with [HHS] to undertake partial expansions").

163 *See Building the Health Insurance Marketplace*, NAT'L CONFERENCE OF STATE LEGS., http://www.ncsl.org/issues–research/health/american–health–benefit–exchanges.aspx#keydates (updated Aug. 21, 2013) (summarizing key exchange implementation dates).

164 FAQ, Dec. 10, 2012, *supra* note 153, at 12 (responding, "no," to a question asking whether states could expand to less than 133% FPL and still receive 100% federal matching funds").

165 *Id.* at 11 (affirming that "there is no deadline by which a state must let the federal government know its intention regarding the Medicaid expansion").

166 *Id.* at 12; *see also* Medicaid and the Affordable Care Act: Premium Assistance, MEDICAID.GOV (Mar. 2013), http://medicaid.gov/Federal–Policy–Guidance/Downloads/FAQ–03–29–13–Premium–Assistance.pdf (noting various options for states to pay for Medicaid enrollees private group coverage premiums, while still requiring states to ensure the same cost–sharing and coverage requirements as Medicaid) [hereinafter *Premium Assistance FAQs*].).

167 *See infra* Part III.C.2 (describing the Arkansas plan).

168 Baker, *supra* note 14 ("Several other states have been closely watching Arkansas's progress.").

169 *Id.*; Johnson, *supra* note 14; *see supra* notes 148–53 and accompanying text.

170 States were given the option to operate their own exchanges, to allow the federal government to do so, or to establish an exchange in partnership with the federal government. "Arkansas has moved quickly to define its role in a partnership exchange, focusing on maintaining flexibility

benefits being delivered through private plans is not new, it is novel to throw Medicaid beneficiaries into the mix of an emerging commercial market to purchase their own plans.[171] In essence, the Arkansas arrangement operates as a government–funded voucher for Medicaid recipients. Other states' negotiations with federal officials received less media attention, but are similarly instructive for understanding how reluctant states might come around to accepting Medicaid expansion.[172]

This Article delineates the "Red State Narrative," meaning the arguments that ultimately stand a good chance of convincing Red State legislators and governors to opt into Medicaid expansion. This Article concludes that states that have invested so long and so deeply in anti–Obamacare rhetoric, steadfastly refusing even the slightest appearance of support for the comprehensive federal reform package, can find a way to accept the generous federal dollars without losing political face.

I write as a resident of Georgia, one of these Red States, where even the Georgia Hospital Association long remained agnostic on the merits of Medicaid expansion in our state.[173] According to various sources, Medicaid expansion would be a financial win–win for Georgia.[174] Health policy and consumer advocacy groups estimate that Medicaid expansion would cover approximately

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and control over insurance plan selection, rating, monitoring and consumer assistance functions including, outreach, education, and an In–person Assister program." The Henry J. Kaiser Family Found., State Exchange Profile: Arkansas (last updated Oct. 29, 2013), http://kff.org/health–reform/state–profile/state–exchange–profiles–arkansas.

171 *See* Rosenbaum & Sommers, *The Great New Experiment*, *supra* note 15, at 8 (emphasizing that "moving Medicaid beneficiaries into a new and untested marketplace raises large challenges even as it creates important opportunities").

172 *See generally infra* Part III.C (describing various states' experiences with Medicaid expansion).

173 Andy Miller, *Georgia Hospital Officials Muted on Medicaid Expansion*, Athens Banner–Herald (last updated May 5, 2013, 8:17 PM), http://onlineathens.com/local–news/2013–05–04/georgia–hospital–officials–muted–medicaid–expansion.

174 *See, e.g.*, John Holahan et al., Kaiser Comm'n on Medicaid & the Uninsured, The Henry J. Kaiser Family Found., The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State–by–State Analysis 8 tbl.ES–1 (Nov. 1, 2012), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384.pdf (estimating a 45.1% increase, or $37.9 billion, in federal funding under Medicaid expansion); Andy Miller, *Studies Point to Savings Under Medicaid Expansion*, Augusta Chronicle (July 25, 2013), http://chronicle.augusta.com/news/health/2013–07–25/studies–point–savings–under–medicaid–expansion; Tony Pugh, *Despite Health Challenges, Southern States Resist Medicaid Expansion*, McClatchy (Apr. 11, 2013), http://www.mcclatchydc.com/2013/04/11/188297/health–challenged–southern–states.html (noting that Georgia would receive a 38.1% increase, or $33.7 billion, in federal funding under Medicaid expansion); William S. Custer, *The Economic Impact of Medicaid Expansion in Georgia*, Pub. No. 74, Healthcare Ga. Found. 4 (2013), http://www.healthcaregeorgia.org/uploads/file/Economic_Impact_Medicaid_GA(1).pdf (estimating that Medicaid expansion would bring additional $40.5 billion federal dollars to Georgia over 2014 to 2023 and add over 70,000 new jobs, resulting in $8.2 billion additional economic output and $276.5 million additional tax revenue); Timothy Sweeney, *Report: Medicaid Expansion Good for Georgia Workers,* Ga. Budget & Policy Inst. Blog (July 19, 2013), http://gbpi.org/report–medicaid–expansion–good–for–georgia–workers.

700,000 currently uninsured people[175] and bring $15 billion more federal dollars into the state's health care system over the first five years of expansion.[176] The state would face a mere two percent increase in current state Medicaid spending. [177] Yet even in the face of such compelling economic arguments in favor of expansion, Georgia's leaders remain steadfastly opposed.[178] If economic self–interest cannot convince states to come on board, what argument can?

The impact of states' decisions not to expand Medicaid will become apparent over the next several years as the health insurance exchanges and other key provisions of the ACA take effect. In states like Georgia, the decision to opt out will result in a significant portion of the population becoming ineligible not only for Medicaid, but also for federal subsidies to purchase private insurance on the exchanges. Yet those individuals will still be subject to the tax penalties for failing to comply with the ACA's individual mandate.[179] In Georgia, this Medicaid "donut hole" could encompass as many as half a million residents.[180]

A. Arguments Against Medicaid Expansion

In order to construct a Red State Narrative, it is helpful first to understand the arguments that must be overcome. In early 2013, the New England Journal of Medicine published an incisive summary of state lawmakers' expressed reasons for opting out of, or remaining undecided about, Medicaid expansion.[181] These objections include financial, public policy, and federalism concerns.

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175 *State Implications of Health Reform in Georgia*, Ga. Health Policy Ctr. 1 fig.1 (May 3, 2010), https://aysps.gsu.edu/sites/default/files/documents/ghpc/State_Implications_of_Health_Reform_in_Georgia%282%29.pdf (including expansion to children, adults with children, and childless adults); Amanda Ptashkin, Presentation, *The Affordable Care Act: What's in it for You and Your Patients?*, Georgians for a Healthy Future, slide 28 (Oct. 29, 2012), http://healthyfuturega.org/pdfs/swog.pdf.

176 *Id.* at slide 33.

177 *Explaining Medicaid, Medicaid 101*, Cover Georgia, http://www.coverga.org/medicaid101/medicaid101.html (last visited Jan. 8, 2014) (estimating a 2% increase representing $714 million in new state spending); *see also* Ptashkin, *supra* note 175, at slide 27 (estimating a 2.7% increase in state Medicaid spending above baseline without expansion).

178 *See* Pugh, *supra* note 174 (summarizing view of nine contiguous Southern states, including Georgia, saying they cannot afford Medicaid expansion under the 90% federal funding arrangement); Kyle Wingfield, *Deal: No Medicaid Expansion for Georgia*, Atlanta Journal–Const. (Aug. 28, 2012, 12:49 PM), http://blogs.ajc.com/kyle–wingfield/2012/08/28/deal–no–medicaid–expansion–for–georgia/ (internal quotation marks omitted) (reporting that Governor Nation Deal said he had "no intentions of expanding Medicaid" and, at a cost of $4.5 billion over 10 years, felt that expansion " ("'is something our state cannot afford").

179 Tammy Luhby, *States Forego Billions by Opting out of Medicaid Expansion*, CNNMoney (July 1, 2013), http://money.cnn.com/2013/07/01/news/economy/medicaid–expansion–states/index.html.

180 *See* Ptashkin, *supra* note 175, at slide 30 (estimating 534,000 would remain ineligible for exchange subsidies or Medicaid/CHIP if state declines expansion).

181 Sommers & Epstein, *supra* note 154, at 496.

The two most commonly cited reasons were concern about the impact of Medicaid expansion on state budgets[182] and the related concern that states would have to raise taxes in order to pay for the expansion.[183] In Georgia, for example, analysis suggests that Medicaid expansion would cost the state between $2.5 and $4.5 billion.[184] Relatively speaking, that is very small amount compared the federal dollars Georgia would receive under expansion.[185] But it is still more than state lawmakers believe the state budget can support.[186] These objections must be understood as suggesting that states like Georgia do not contemplate an alternative, fully state–funded program for currently uninsured low–income residents. Given the very generous federal funding extended under the ACA, a state–based approach to cover the entire Medicaid expansion population would almost certainly result in an even larger impact on the state budget.

Lawmakers also expressed concern that Medicaid expansion would adversely impact state budgets by increasing the costs of covering not only newly eligible beneficiaries, but also currently eligible beneficiaries. This "woodwork effect" is associated with the ACA's Medicaid outreach efforts and enrollment simplification.[187] This argument reveals state lawmakers' fundamental reluctance to support government welfare programs and their preference for keeping Medicaid rolls down through de facto under–enrollment.

Another manifestation of state lawmakers' budgetary concerns is revealed in their initial interest in partial Medicaid expansion. If states could expand Medicaid up to only 100%, rather than the statutory 138% FPL, they could offset even more costs onto the federal government. That is because under the ACA, federal tax credits to purchase private insurance on the exchanges are available for people between 100% and 400% FPL.[188] Accordingly, if states could expand their Medicaid programs only up to 100%, anyone above that

182 *Id.* at 498 (finding that 92% of governors opposing Medicaid expansion expressed concerns about impact on state budget).

183 *Id.* (noting that just over half of governors expressed concerns that states would have to raise taxes to pay for expansion).

184 Max Blau, *This Georgia Hospital Shows Why Rejecting Medicaid Isn't Easy*, Wash. Post Wonkblog (June 26, 2013, 3:24 PM), http://www.washingtonpost.com/blogs/wonkblog/wp/2013/06/26/this–georgia–hospital–shows–why–rejecting–medicaid–isnt–easy/ (reporting state cost estimates cited by Governor Deal); *see* Wingfield, *supra* note 177 (same).

185 Blau, *supra* note 184 (reporting that Georgia stands to receive $33 billion over a decade should it choose to accept Medicaid expansion).

186 *Id.* (citing Governor Deal's response to cost estimates); *see* Wingfield, *supra* note 178 (quoting Governor Deal).

187 *See* Sommers & Epstein, *supra* note 154, at 498 (noting that some governors "pointed to the so–called woodwork effect, in which the ACA could draw previously eligible but unenrolled persons into Medicaid, at greater cost to the state"); CBO, July 2012, *supra* note 55, at 9 (noting that states, and the CBO, expect an "increase in enrollment among those who would have been eligible under prior law and would not qualify for the higher federal matching rates").

188 I.R.C. § 36B(c)(1)(A) (2012) (providing for premium assistance tax credits for purchase of qualified health plans).

level, up to 400% FPL, would be eligible for federally funded tax credits.[189] Accordingly, at least that marginal group between 100% FPL and 138% FPL would be covered on the federal government's, not the states', tab.

Setting aside budgetary concerns, other objections to Medicaid expansion stem from broader state resistance to federal health reform, most saliently expressed in states' legal challenges to the constitutionality of the individual mandate and Medicaid expansion.[190] States' lawsuits were grounded in the Tenth Amendment and federalism principles regarding the proper scope of federal vis–à–vis state power.[191] Many opting–out states simply do not want to give up control and be subject to further federal oversight into areas that they consider more properly the realm of traditional state authority.[192] Under this view, lawmakers' objections are not so much to Medicaid in particular, but to the expansion of federal programs in general.

Several state lawmakers doubted whether the federal government would actually honor its generous offer of federal matching dollars under the terms prescribed in the ACA.[193] States' existing Federal Medical Assistance Percentage (FMAP) is determined annually, based on the relative poverty level of participating states, with 50% federal match being the minimum.[194] The ACA's considerably more generous 100% and phased–down 90% federal funding does not contemplate adjustments or federal agency discretion over the funding level.[195] Accordingly, it seems that an act of Congress, quite literally, would be required for federal funding to be reduced. Given the great hurdles Congress surmounted to enact the ACA in the first place, and the multiple

189 *See* Sommers & Epstein, *supra* note 154, at 499 (discussing states' interest in partial expansion).

190 *See* Steven Schwinn, *The ACA and the Tenth Amendment*, SCOTUSblog, (Aug. 5, 2011, 1:38 PM), http://www.scotusblog.com/2011/08/the–aca–and–the–tenth–amendment/. Proponents of ACA find such constitutional arguments to lack any real merit*;* Pugh, *supra* note 174 (quoting Joan Alker, co–executive director of the Center for Children and Families at Georgetown University) ("The opposition is purely ideological. It's the tea party faction of the Republican Party.").

191 *See* Schwinn, *supra* note 190.

192 *See* Sommers & Epstein, *supra* note 154, at 498 (citing governors' concerns about lack of state flexibility). Curiously, however, many of the states that refuse Medicaid expansion on federalism grounds also refuse to establish state–based health insurance exchanges, with the result being that their exchanges will be established and administered by the federal government. That approach cedes considerable authority over state insurance markets to federal authorities, contrary to the Tenth Amendment rhetoric.

193 *See id.* at 498–99 (noting that more than half of governors opposing expansion "predicted that the federal government would renege on the generous terms of the ACA").

194 Kaiser Comm'n on Medicaid and the Uninsured, The Henry J. Kaiser Family Found., Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP) 1–2 (2012), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8352.pdf; *see also* 2013–14 FMAP Calculations , 77 Fed. Reg. 71,420 (Nov. 30, 2012), http://www.gpo.gov/fdsys/pkg/FR–2012–11–30/pdf/2012–29035.pdf (citing notice of the current year's FMAP calculations in the Federal Register).

195 *See* 42 U.S.C. § 1396d(y)(1) (2012).

failed attempts to repeal all or part of the law, it is hard to imagine that such a Medicaid funding amendment would be viable. Nevertheless, a number of states that eventually agreed to Medicaid expansion included "circuit breakers" or other provisions in their legislation, which would automatically repeal or call for reconsideration of the state expansion legislation, should the federal funding level change.[196]

Other objections express fundamental policy disagreements regarding government assistance and individual responsibility. Opposing state leaders and representatives described the Medicaid program as "broken"[197] and the entire notion of public entitlements as fostering dependency.[198] Several governors oppose Medicaid expansion based on the belief that it is bad policy to funnel more money, federal or state, into a failing public program.[199] Objections to the Medicaid program, or public entitlements generally, obviously go beyond the specific issue of whether to expand Medicaid to a new group of beneficiaries. It bears emphasis, however, that through their participation in the existing Medicaid program these states have already expressed some support for publicly funded health care for certain groups.

Several state lawmakers effectively dodged the question, citing uncertainty and need for more information as their reasons for opting out of Medicaid expansion at this time.[200] The wait–and–see approach is defensible; there are certainly many unanswered questions about how Medicaid expansion will work, how much it will cost, and how effectively it will provide essential medical care to enrollees. A number of states are waiting in the wings to see how things unfold and what other alternatives to expansion, such as the Arkansas plan, may become available.[201]

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196 *See, e.g.*, Fernanda Santos, *Medicaid Expansion is Delicate Maneuver for Arizona's Republican Governor*, N.Y. Times (Jan. 19, 2013), www.nytimes.com/2013/01/20/us/politics/medicaid–expansion–is–delicate–maneuver–for–arizona–governor.html ("[Arizona governor Jan Brewer's expansion] plan includes a 'circuit breaker' to automatically freeze coverage for childless adults if the federal government drops its share of matching funds below 80 percent."); Kyle Cheney, *Chris Christie Takes Obamacare Medicaid Expansion*, Politico (Feb. 26, 2013, 1:20 PM), http://www.politico.com/story/2013/02/chris–christie–to–take–obamacare–medicaid–expansion–88105.html ("[New Jersey governor Chris] Christie promised to withdraw his support if Washington reneges on its commitment. 'If that ever changes because of adverse actions by the Obama administration or broken promises, I will end it as quickly as it started,' he said.").

197 Sommers & Epstein, *supra* note 154, at 498 ("[Governor] Rick Perry (R–TX) said that adding uninsured Texans to Medicaid is 'not unlike adding a thousand people to the Titanic.'").

198 *Id.* ("[Governor] Dennis Daugaard (R–SD) declared that 'able–bodied adults should be self–reliant' . . . .").

199 *See, e.g.*, Pugh, *supra* note 174 (quoting spokesman for Mississippi governor Phil Bryant) ("From 2003 to 2012, Mississippi spent more than $9 billion on Medicaid and the state's poor health indicators have remained unchanged or worsened . . . . 'So why would we throw even more money we don't have at the issue and expect some miraculous change in outcomes?'").

200 Sommers & Epstein, *supra* note 154, at 498 tbl.2 (three–quarters of undecided governors cited need for more information).

201 *See, e.g.*, *Georgia Studying Medicaid Expansion Options*, Athens Banner–Herald (May

B. Arguments for Medicaid Expansion

A number of arguments, including financial, social welfare, morality, and public health, favor Medicaid expansion. As suggested in the Introduction, the strongest, seemingly irrefutable, argument in favor of Medicaid expansion is economic.[202] Congress surely expected the generous federal funding for Medicaid expansion to incentivize states to opt in.[203] A recent RAND simulation estimated that the fourteen opt–out states would forgo a total of $8.4 billion in federal funding and would spend an additional $1 billion in uncompensated care costs by not expanding their Medicaid programs.[204]

Various special interest and policy groups have conducted state–specific analyses demonstrating the net benefits of accepting federal funding for Medicaid expansion.[205] For example, West Virginia's Governor Earl Ray Tomblin hired an actuarial firm and two health economists to model the impact of insurance exchange implementation and Medicaid expansion.[206] Expansion in that state would add about 91,500 low–income residents to Medicaid, bringing $5.2 billion in new federal funding while costing the state a relatively modest $375.5 million.[207] Armed with this data, Tomblin became one of the latest Democratic governors to accept Medicaid expansion.[208]

22, 2013), http://onlineathens.com/local–news/2013–05–22/georgia–studying–medicaid–expansion–options (noting that state budget analysts are assessing the financial impact of expansion and studying various models, including the novel Arkansas approach).

202 *See, e.g.*, Holahan et al., *supra* note 174, at 5 & fig.ES–3 (indicating that incremental cost of expansion for states would be $8 billion (0.3% increase), compared to incremental cost to federal government of $800 billion (21% increase) over 2013–2022 period); Rudowitz & Stephens, *supra* note 154, at 7 (estimating that twenty–one opting–out states would forgo $345.9 billion in federal funds over 2013–2022 period); Price & Eibner, *supra* note 5, at 1033 (noting that fourteen opting–out states would forgo $8.4 billion in federal payments); Luhby, *supra* note 179 (quoting Urban Institute's John Holahan) ("You can't make an economic case against expansion.").

203 CBO, July 2012, *supra* note 55, at 9 ("One significant incentive for states to undertake the Medicaid expansion . . . is that the federal government is scheduled to cover a very large share of the costs of that expansion.").

204 Price & Eibner, *supra* note 5, at 1033–34.

205 *See* Abby Goodnough & Robert Pear, *Governors Fall away in G.O.P. Opposition to More Medicaid*, N.Y. Times (Feb. 21, 2013), http://www.nytimes.com/2013/02/22/us/politics/gop–governors–providing–a–lift–for–health–law.html ("Every few days, state hospital associations and advocates for poor people issue reports asserting that the economic benefits of expanding Medicaid would outweigh the costs. In recent weeks, such reports have been issued in Idaho, Indiana, Mississippi, Missouri, Texas, Virginia and Wisconsin.").

206 Margaret Newkirk & Mark Niquette, *West Virginia Governor Backs Medicaid Expansion for Poor*, Bloomberg (May 2, 2013), http://www.bloomberg.com/news/2013–05–02/west–virginia–governor–backs–medicaid–expansion–for–poor.html.

207 *Id.*

208 *See* Sy Mukherjee, *West Virginia Accepts Medicaid Expansion as Time Runs Out for Other Highly–Uninsured States*, ThinkProgress (May 2, 2013, 2:55 PM), http://thinkprogress.org/health/2013/05/02/1954191/west–virginia–will–expand–medicaid/; Newkirk & Niquette, *supra* note 206.

Likewise, in Ohio, a "decisive factor" in Republican Governor John Kasich's decision to support Medicaid expansion was a health policy study demonstrating that the economic benefits of expansion outweigh the costs to the state.[209] The Ohio study, prepared by The Ohio State University, the Health Policy Institute of Ohio, and the Urban Institute and Regional Economic Models, was "a major watershed moment," allowing Medicaid expansion proponents to reframe the issue as improving both the state budget and economy, while extending coverage to more than 455,000 people.[210] After months of lobbying by religious, health care, and business groups, the release of the study finally shifted Governor Kasich in favor of expansion.[211]

There are many ways to measure the estimated costs and savings from Medicaid expansion. Some studies consider only the expected federal funding.[212] Other models include savings from reducing state programming aimed at the indigent, such as mental health counseling, substance abuse treatment, uncompensated care funding, and public health agencies.[213] Other studies estimate indirect benefits, such as job creation and tax revenues likely to come from increased federal funding.[214] For example, in Virginia, state officials estimated that the state would face increased spending of $137 million over ten years to expand Medicaid.[215] But when additional tax revenue resulting from expansion was factored in, the estimate shifted to $555 million in savings.[216] To date, Virginia has not decided whether to expand Medicaid, and the decision will likely wait until after the November 2013 gubernatorial election.[217]

Governors supportive of Medicaid expansion seemed to take the economic arguments as a given, instead focusing on policy reasons. In the New England Journal of Medicine article, among the eighteen governors surveyed supporting Medicaid expansion, the number one reason given was that it will help cover the uninsured.[218] The second reason was that it would bolster their states' prior health

209 *See* Goodnough & Pear, *supra* note 205.

210 *Id.* (quoting Ari Lipman, chairman of Northeast Ohio Medicaid Expansion Coalition).

211 *Id.*

212 *See, e.g.*, Price & Eibner, *supra* note 5, at 1030 (using microsimulation to demonstrate the effect of Medicaid opt–out on coverage and state spending).

213 *See* Luhby, *supra* note 179 (describing different studies in various states).

214 *Id.*; *see also* Custer, *supra* note 174, at 4 (estimating additional jobs and tax revenue resulting from Medicaid expansion in Georgia); Rudowitz & Stephens, *supra* note 154, at 8 ("States that implement the Medicaid expansion could also see savings or offsets and broader economic effects that vary by state and cannot be modeled using national data.").

215 Luhby, *supra* note 179 (citing study).

216 *Id.*

217 *See* Julian Walker, *Va. Senators Named to Medicaid Review Panel*, Virginian–Pilot (Norfolk, Va.) (Apr. 11, 2013, 8:07 PM), http://hamptonroads.com/2013/04/va–senators–named–medicaid–review–panel (noting that the Democratic gubernatorial candidate Terry McAuliffe supports expansion, while Republican candidate Ken Cuccinelli opposes it).

218 Sommers & Epstein, *supra* note 154, at 498 tbl.2.

care reform efforts.[219] These supportive governors emphasized that Medicaid expansion would actually save their states money by replacing state dollars with federal dollars.[220] Opt–in states, in many cases, are already providing some form of assistance to low–income adults who previously did not qualify for Medicaid, either as optional Medicaid groups or as separate state programs.[221] Similar voluntary expansion may not exist in many Red States.[222] The governors' reasons for supporting Medicaid expansion suggest an established policy preference for government involvement in social welfare and health care.

Even some initially reluctant states have come around to accept Medicaid expansion due to political pressure. Health care providers, particularly hospitals, have been vocal in their support for expansion.[223] This, in part, is because of a deal struck in the ACA. Well before the ACA, hospitals that treat a disproportionate share of uninsured or underinsured patients were eligible for additional federal disproportionate share hospital (DSH) funding.[224] The ACA significantly cut DSH funding,[225] with the expectation that as more individuals became insured through employer incentives, health insurance exchanges, and Medicaid expansion, providers would see a lower portion of uninsured patients.[226] But in Medicaid opt–out states, a large segment of the group whom Congress expected to be newly covered would remain uninsured. Providers in those states would face the double burden of reduced DSH payments along with the same rates of uninsured patients. Despite the clear logic of this argument, lawmakers in many Red States remain unpersuaded.[227]

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219 *Id.*

220 *Id.*

221 *See* Martha Heberlein et al., Kaiser Comm'n for Medicaid and the Uninsured, The Henry J. Kaiser Family Found., Getting into Gear for 2014: Findings from a 50–State Survey of Eligibility, Enrollment, Renewal, and Cost–Sharing Policies in Medicaid and CHIP, 2012–2013 1, 33 tbl.4 (Jan. 23, January 2013), http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8401.pdf (displaying income eligibility levels for some states' optional coverage for low–income non–disabled, nonelderly adults).

222 *See id.* (reporting that Georgia, for example, provides Medicaid coverage only to parents of dependent children, and only up to 27% or 48% FPL depending on employment status).

223 *See* CBO, July 2012, *supra* note 55, at 9 ("Pressure to expand Medicaid coverage is . . . likely to come from health care providers that stand to gain when more people have coverage. . . . [H]ospitals that will receive smaller disproportionate share payments from Medicaid under the ACA may exert pressure on states to make up for those losses by expanding Medicaid eligibility.").

224 *See generally* Medicaid Program; State Disproportionate Share Hospital Allotment Reductions, 78 Fed. Reg. 28,551, 28,553 (proposed May 15, 2013) (to be codified at 42 C.F.R. pt. 447) (providing legislative history and overview of DSH allotments).

225 PPACA, Pub. L. No. 111–148, § 2551, 124 Stat. 119, 312–13 (2010) (codified as amended at 42 U.S.C. § 1396r–4(f) (2012)) (reducing payments to DSH payments).

226 *See* Goodnough & Pear, *supra* note 205 ("The change of heart for some Republican governors has come after vigorous lobbying by health industry players, particularly hospitals. Hospital associations around the country signed off on Medicaid [DSH] cuts . . . on the assumption that their losses would be more than offset by new paying customers . . . .").

227 *See* Blau, *supra* note 184 (quoting vice president of large Atlanta public hospital) (ex-

Another constituent group that has urged states to accept federal funding for Medicaid expansion are employers.[228] Employers in opt–out states face two possible financial burdens. First, they may feel pressure to offer insurance to otherwise Medicaid–eligible employees. Second, they may have to shoulder higher premiums for their currently insured employees as providers try to offset uncompensated care costs. If federal dollars can be used to insure low–income workers, states receive a double benefit—relieving their business community of a potentially crippling expense and shouldering the federal budget, rather than their own, with the cost. Other studies suggest that the infusion of federal funding could boost state economies and create new jobs.[229] A study in Kansas, for example, concluded that full Medicaid expansion would bring in more than $3 billion to the state's economy and create 4000 new jobs by 2020.[230] A study in Georgia estimated that over the next decade 70,343 jobs would be created, bringing $8.2 billion to statewide economic output and generating state and local tax revenue on average $276.5 million annually.[231]

There are other arguments, not expressed in the New England Journal of Medicine survey, but which could persuade lawmakers to expand Medicaid. Some advocates of expansion would surely urge that it is simply the morally right thing to do.[232] The ACA brings the U.S. health care system closer to a

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plaining that the expected 50% cut in DSH payments is a "double whammy" without the offset of more insured patients from Medicaid expansion); Rudowitz & Stephens, *supra* note 154, at 8 fig.13 (citing John Holahan et al., The Kaiser Comm'n on Medicaid and the Uninsured, The Henry J. Kaiser Family Found., The Cost of Not Expanding Medicaid 13 fig.11 (July 17, 2013), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8457–the–cost–of–not–expanding–medicaid4.pdf) (noting double loss of expected Medicaid payments and DSH cuts on non–expansion states); Pugh, *supra* note 174 (noting trade–offs between increased federal funding for Medicaid expansion and savings for indigent care). *See generally* Sommers & Epstein, *supra* note 154 (discussing states' continued resistance to expansion).

228 *See* Pugh, *supra* note 174 (quoting Joan Alker, co–executive director of the Center of Children and Families at Georgetown University) ("There are no big interests that are against this. The hospitals are for it. The managed care industry is for it. Most of the employer groups are for it."). See, for example, Custer, *supra* note 174, at 5 tbl.2, for a list of the top ten industries in Georgia that would be impacted by Medicaid expansion, including not only health care providers but real estate establishments, food services and drinking places, employment services, wholesale trade businesses, and services to buildings and dwellings.

229 *See* Rudowitz & Stephens, *supra* note 154, at 8 fig.14 (citing John Holahan et al., The Kaiser Comm'n on Medicaid and the Uninsured, The Henry J. Kaiser Family Found., The Cost of Not Expanding Medicaid 16–17 (July 17, 2013), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8457–the–cost–of–not–expanding–medicaid4.pdf) (noting, among other fiscal implications for expansion states, increased jobs and tax revenues); Pugh, *supra* note 174 (citing studies).

230 Chris Brown et al., Kan. Hosp. Ass'n, Economic and Employment Effects of Expanding KanCare in Kansas 8–9 (Feb. 2013), http://media.khi.org/news/documents/2013/02/18/KanCare_Expansion_Report.pdf.

231 Custer, *supra* note 174, at 4 (summarizing findings).

232 *See* Pugh, *supra* note 174 (quoting Charles Blahous, a senior research fellow at the Mercatus Center, a market–oriented research center at George Mason University) ("'From a social

vision of health care as a right of all persons, not a privilege of those with means to pay for it.[233] Under this view, expansion of Medicaid to a new group of "deserving poor," specifically low–income childless adults, is a step in the right direction. If state lawmakers could philosophically agree with that position, it would be easier to sell them on various aspects of the ACA, including Medicaid expansion.

The morality argument has some traction among certain constituents, which view might be marshaled to encourage Red State lawmakers to opt in. A form of that argument has been adopted and urged by some religious organizations, including Catholic bishops, who have come out in support of Medicaid expansion.[234] Also, a recent poll of voters in the Deep South showed strong support among both African–Americans and non–Hispanic whites.[235] The most popular reason cited by survey respondents, approximately 57%, for supporting Medicaid expansion is that the program operates as a safety net to protect low–income people.[236] This argument is consistent with the morality view that the government has an obligation to provide for vulnerable members of society. If those voicing the morality argument represent a significant voter demographic, these arguments may become more persuasive.

Another economic argument in favor of expansion is that increasing the rates of insured individuals in the population will improve overall health, and thereby, lower health care costs.[237] In many Southern states, the safety net for

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or humanitarian perspective, you could argue Medicaid expansion is a winner. But from a purely financial perspective, it's clearly a loser.' . . .").

233 *See* Robert Pear, *Sebelius Defends Law and Zeal in Push to Insure Millions*, N.Y. Times (July 8, 2013), http://www.nytimes.com/2013/07/09/us/politics/sebelius–defends–law–and–zeal–in–push–to–insure–millions.html ("[Secretary Sebelius's] job is . . . to nudge the nation toward a new era in which health care is a right, not a privilege — all this over the opposition of Republicans in Congress and in many state capitols, who are poised to pounce on any misstep.").

234 *See, e.g.*, Newkirk & Niquette, *supra* note 206 (noting that Bishop Bransfield of the Diocese of Wheeling– Charleston wrote to West Virginia Governor Tomblin, on behalf of the diocese's 83,000 Catholics, urging him to expand Medicaid, stating that "Catholic social teaching supports adequate and affordable health care for all"); Goodnough & Pear, *supra* note 205 (noting that a moral dimension was added to the campaign because of support from religious leaders such as the Roman Catholic bishops in Salt Lake City and Little Rock who have urged their state officials to expand Medicaid).

235 David A. Bositis, *The Deep South and Medicaid Expansion: The View from Alabama, Georgia, Louisiana, Mississippi, and South Carolina*, Joint Ctr. for Pol. & Econ. Stud. 1, 5 (May 2013), http://jointcenter.org/sites/default/files/upload/research/files/The%20Deep%20South%20and%20Medicaid%20Expansion.pdf.

236 *Id.* at 20. Other reasons why at least a plurality of respondents considered Medicaid important included the fact that the respondent knew someone who received Medicaid coverage in the past, may need to rely on Medicaid in the future, and the program covers nursing home and long–term care. *Id.* at 14–19.

237 *See* Rudowitz & Stephens, *supra* note 154, at 3 (citing the Institute of Medicine's "authoritative report" demonstrating that "health insurance coverage is associated with better health outcomes"). *But see* Katherine Baicker et al., *The Oregon Experiment – Effects of Medicaid on Clinical Outcomes*, 368 New Eng. J. Med. 1713, 1713 (2013) ("Medicaid coverage generated no significant

low–income, uninsured residents, absent Medicaid expansion, is the public hospital system. But hospital care and emergency rooms do a particularly poor job of primary care and prevention.[238] In terms of improving health and lowering health care costs, the Medicaid program is actually ahead of the curve in prioritizing preventive care for children. Historically, Medicaid policy reflects a strategy to improve health as well as to contain costs.[239] The ACA now takes that idea to other groups of insureds, requiring full coverage for preventive care under commercial health insurance plans.[240] Opt–out states' failure to cover preventative and primary care for low–income residents could have adverse effects on individual and public health outcomes. State–specific estimates of the economic of Medicaid expansion should consider such negative consequences.

C. Case Studies

To date, ten Republican–controlled states have indicated support for expanding Medicaid. The current roster includes: Arizona, Arkansas, Florida, Michigan, Nevada, New Jersey, New Mexico, North Dakota, Ohio,[241] and

improvements in measured physical health outcomes in the first 2 years, but it did increase use of health care services, raise rates of diabetes detection and management, lower rates of depression, and reduce financial strain.").

238 *See* Pugh, *supra* note 174 (citing Emory professor Kenneth Thorpe's observation that the Southern states' approach to uninsured patients has been investment in large public hospitals, which do a poor job of primary care and prevention).

239 *See* Sara E. Wilensky & Elizabeth A. Gray, *Existing Medicaid Beneficiaries Left Off the Affordable Care Act's Prevention Bandwagon*, 32 Health Aff. 1188, 1188 (2013) (observing that newly eligible Medicaid beneficiaries may receive coverage for preventive care even in states where existing Medicaid beneficiaries do not); Laura Snyder, Coverage of Preventive Services for Adults in Medicaid, Kaiser Comm'n for Medicaid and the uninsured, The Henry J. Kaiser Family Found. (Sept. 2012), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8359.pdf; Matthew F. Savage et al., *Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs*, 114 Pediatrics e418, e423 (2004), http://pediatrics.aappublications.org/content/114/4/e418.full.pdf ("Preschool–aged children who used early preventive dental care incurred fewer dentally related costs, compared with children who began care at a later time."); Sean Jessee, Comment, *Fulfilling the Promise of the Medicaid Act: Why the Equal Access Clause Creates Privately Enforceable Rights*, 58 Emory L.J. 791, 827 (2009) (arguing that preventive care decreases long–term costs of indigent care).

240 *See Preventive Services Covered Under the Affordable Care Act*, *See* U.S. Dep't of Health & Human Servs., http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive–services–list.html#CoveredPreventiveServicesforAdults (last visited Jan. 8, 2013); Comm. on Preventative Servs. For Women, Clinical Preventative Services for Women: Closing the Gap 16–18 (2011) (discussing studies demonstrating economic benefits of preventive services and noting that "[t]he ACA intends to mitigate these issues"); Timothy S. Jost, *Implementing Health Reform: Preventive Services*, Health Aff. Blog (July 15, 2010, 11:48 AM), http://healthaffairs.org/blog/2010/07/15/implementing–health–reform–preventive–services (stating that one of four planned benefits from the preventive coverage rule is "[s]ome savings due to lower health care costs").

241 *See* Advisory Bd. Daily Briefing, *supra* note 4 (summarizing states' positions as of July 2013 on Medicaid expansion).

Pennsylvania.[242] Despite support from governors, Medicaid expansion remains not fully enacted in at least some of these Red States. This article draws from case studies of the dynamics surrounding Medicaid expansion in Arizona, Arkansas, Michigan, and Florida in order to articulate the Red State Narrative. In the first two states, both the governors and legislatures approved expansion. In the latter two, the governors' support for expansion could not gain legislative approval before the 2013 sessions ended.

1. Arizona.—Arizona's Republican governor, Jan Brewer, faced a political dilemma in deciding whether to support or oppose Medicaid expansion in her state. Her conservative base staunchly opposed the Affordable Care Act. Any expression of support for implementing President Obama's signature domestic legislation risked alienating them.[243] Her state constituency, however, was heavily Latino, a demographic that largely supports Medicaid expansion and which would be a substantial portion of the newly eligible population.[244] Similarly, Republican governors of three Southwestern states, Arizona, Nevada, and New Mexico, ultimately backed the option to accept the federal funding for Medicaid expansion.[245]

Arizona's Governor Brewer is something of a Tea Party darling, a highly vocal critic of the Affordable Care Act, and strong supporter of her state's strict immigration legislation, which allows police to stop and question people suspected of being in the country illegally.[246] But under pressure from the newly politically powerful Latino constituency, Brewer announced an about–face on Medicaid expansion.[247] She struck chords of "compassionate conservatism"[248] and noted that expansion would be a cost–effective way of insuring the working

242 *See* Daniel Kelley, *Pennsylvania Proposes Alternative to Expansion of Medicaid*, NBCNEWS.COM (Sept. 17, 2013), http://www.nbcnews.com/health/pennsylvania–proposes–alternative–expansion–medicaid–4B11181090 (discussing Republican Governor Tom Corbett's proposal).

243 *See* Santos, *supra* note 196.

244 *Id.* (citing a National Council of La Raza report indicating that 3.1 million additional Latinos would be covered under full national expansion of Medicaid, accounting for about half of the newly insured Latino population).

245 *See id.*

246 David Schwartz, *Arizona Governor Jan Brewer Signs Medicaid Expansion*, REUTERS (June 17, 2013), http://www.reuters.com/article/2013/06/17/us–usa–arizona–medicaid–idUSBRE95G12N20130617. In a controversial decision, the U.S. Supreme Court upheld that portion of the Arizona immigration law. *See* Arizona v. United States, 132 S. Ct. 2492, 2510 (2012) (holding that it was improper to enjoin this provision of Arizona state law because state courts had been afforded no opportunity to construe it and there was no evidence its enforcement would conflict with federal immigration law).

247 *See* Santos, *supra* note 196.

248 *See id.* (quoting Barrett Marson, a public relations consultant on his understanding of Governor Brewer's decision) ("'[Ms. Brewer's decision was, in part] about saying, 'I want to show American who I really am' and that person is a compassionate conservative who thinks there should be a safety net for people in the bottom rung.").

poor,[249] many of whom would include the Latino immigrant population. Her position implicitly recognized that her immigration position may no longer be politically tenable in that region of the country.[250] To carry her support for Medicaid, Governor Brewer rallied business and health care groups, which also strongly supported expansion.[251] In June 2013, both houses of the Republican–controlled legislature passed expansion legislation by comfortable margins.[252] Medicaid expansion in Arizona is predicted to add approximately 300,000 new enrollees and bring $1.6 billion in federal dollars to the state.[253]

The other Southwestern states with Republican governors faced similar constituent pressure.[254] Nevada's Republican governor, Brian Sandoval, on December 11, 2012, announced that the state would participate in Medicaid expansion.[255] He noted that he "never liked the Affordable Care Act because of the individual mandate it places on citizens" but acknowledged the Court's decision to uphold it.[256] Accordingly, he felt "forced to accept it as today's reality."[257] The Republican leadership in the state legislature immediately supported the governor's position.[258] Medicaid expansion is expected to enroll 78,000 Nevadans and bring $700 million in federal funding over the first three years.[259]

New Mexico's Republican governor, Susana Martinez, also announced support for Medicaid expansion in January 2013, noting that the decision could potentially expand coverage to nearly 170,000 low–income, uninsured residents.[260] Giving a nod to the morality argument, Governor Martinez cited an "obligation to provide an adequate level of basic healthcare services for those most in need in our state."[261] New Mexico's expansion includes a "circuit

249 Kathleen Doheny, *Arizona OK's Medicaid Expansion; Move Will Extend Health Care to 300,000 Residents Under Affordable*, WebMD (June 18, 2013), http://www.webmd.com/health–insurance/news/20130614/arizona–oks–medicaid–expansion.

250 *See* Santos, *supra* note 196.

251 Schwartz, *supra* note 246.

252 *Id.*

253 *Id.*

254 *See* Santos, *supra* note 196 ("Republican governors bucked the party line in the Southwest, where Latinos are at once a significant slice of the poor population and a powerful voting bloc.").

255 Anjeanette Damon, *Sandoval Opts to Expand Medicaid Coverage for Nevada's Neediest*, Las Vegas Sun (Dec. 11, 2012), http://www.lasvegassun.com/news/2012/dec/11/sandoval–supports–medicaid–expansion–nevada/.

256 *Id.*

257 *Id.*

258 Santos, *supra* note 196.

259 *Id.*

260 *See* Dennis Domrzalski, *New Mexico to Join Medicaid Expansion Program*, Albuquerque Bus. First (Jan. 9, 2013), http://www.bizjournals.com/albuquerque/news/2013/01/09/new–mexico–to–join–medicaid–expansion.html.

261 *Id.*

breaker," making the law contingent on the federal government's maintaining the ACA's promised level of funding.[262]

The challenge with drawing lessons for the Red State Narrative from the experiences of Arizona and other Southwestern states is that the political forces at work there may be uniquely regional. Accepting the strong economic arguments in favor of expansion, the "plus" factor in those states seemed to be the growing political strength of the Latino population. That factor may not hold the same sway in the entrenched Southern Red States. Recent polling, however, suggests strong support among African–Americans, 85.3%, in five Southern states.[263] That constituency might be marshaled in similar fashion to encourage expansion.[264]

So far, however, public opinions have not been sufficient to overcome the overwhelming political rhetoric of states' rights and deep opposition to expansion of the federal government's role in health care. The poll of Southern states further tried to gauge the strength of arguments in favor of Medicaid expansion. The most convincing argument was the suggestion that expansion could create new jobs, stimulate economic activity, and generate new tax revenue in the state. According to the survey, one–third of those polled who initially opposed Medicaid expansion said this information would make them more likely to support it.[265] A majority of African–Americans who had opposed expansion liked this argument, while the number was smaller for whites.[266] Not surprisingly, this argument plays to the Red State preference for private markets and promotion of commerce, more than to morality or social welfare policy arguments.

Opponents of Medicaid expansion were also somewhat persuaded by the fact that for every one dollar the state spent, the federal government would spend nine dollars.[267] That argument is simply a truism of the funding approach under the ACA, but perhaps resonates with those concerned about the federal government unfairly burdening states. Opponents were less persuaded by the suggestions that many low–income people would remain uninsured if expansion were not approved, that opting–out states would be effectively subsidizing opting–in states, and that states could withdraw from Medicaid expansion after the first three years of full federal support ended.[268]

In sum, the lesson from Arizona is that the morality argument regarding

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262 *See id.*

263 Bositis, *supr*a note 235, at 5 (survey conducted in Alabama, Georgia, Louisiana, Mississippi, and South Carolina).

264 A majority of non–Hispanic whites in the South also support Medicaid expansion. *Id.* (reporting 53.3% support expansion).

265 *Id.* at 12–13 tbl.2.

266 *See id.* at 13 tbl.2.

267 *Id.* at 11–12 tbl.2 (noting that 27% of respondents indicated that this argument would make them somewhat more likely to support expansion).

268 *Id.* at 10–11.

helping the uninsured and providing some basic entitlement or "right" to health care, which typically is unpersuasive to Red State governors, can become persuasive when the population expected to benefit from the policy represents a significant voter constituency. A substantial portion of the Medicaid expansion population in Southwestern states like Arizona are Latinos, an increasingly powerful political group. Thus, economic arguments, plus voter demographics, are key elements of the Red State Narrative.

2. Arkansas.—Arkansas's private insurance market approach to Medicaid expansion has been touted as a "game changer,"[269] a demonstration of maximum flexibility for states hesitant to expand Medicaid and reluctant to expand government welfare programs. Arkansas is among the Red States with a partisan split in the statehouse; Governor Mike Beebe is a Democrat, while the legislature is staunchly Republican.[270] The plan, approved by HHS Secretary Kathleen Sebelius and enacted by the Arkansas legislature,[271] authorizes the state to enroll the Medicaid expansion population in private insurance plans. Specifically, the new Medicaid population will be allowed to pick among plans available on the newly created state health insurance exchanges, the same plans in which small employers and other individuals will be enrolling, once those exchanges open.[272] In effect, Arkansas will use the federal matching dollars offered to opting–in states to pay for new Medicaid enrollees' premiums for private health plans. Currently, Arkansas does not cover non–disabled, childless adults at all and covers parents of eligible children only up to 17% FPL.[273] Medicaid expansion could add as many as 250,000 new individuals to the rolls in that state.[274]

The private plan approach to Medicaid expansion sounds radical and certainly attracted the attention of commentators and other holdout states.[275] But in fact, this "premium support" option has been available since Medicaid's

269 *See* Rosenbaum & Sommers, *The Great New Experiment*, *supra* note 15, at 8.

270 Julie Rovner, *Arkansas Medicaid Expansion Attracts Other States' Interest*, NPR (Mar. 26, 2013), http://www.npr.org/blogs/health/2013/03/26/175301509/arkansas–medicaid–expansion–attracts–other–states–interest.

271 *See* S.B. 1020, 89th Gen. Assemb., Reg. Sess. (Ark. 2013) (enacted as 2013 Ark. Acts at 1497), *available at* http://www.arkleg.state.ar.us/assembly/2013/2013R/Acts/Act1497.pdf.

272 Rovner, *supra* note 270.

273 *Id.*

274 *Id.*

275 *See id.* (citations and internal citation marks omitted) ("[F]inding a way to do the expansion through private insurance coverage will open a door to a conversation that was not otherwise taking place."); Kelley, *supra* note 242 ("[M]odeled on similar proposals in Iowa and Arkansas, where Republican officials have also resisted efforts to expand Medicaid eligibility under Obama's Affordable Care Act . . . ."); Rosenbaum & Sommers, *The Great New Experiment*, *supra* note 15, at 7 (noting that other states, including Ohio, are exploring similar arrangements).

inception in 1965[276] and employed to varying degrees by states over the years.[277] More typically, these arrangements allow states to pay premiums toward employer–sponsored health plans for Medicaid–eligible workers who are offered that type of coverage.[278] CHIP also provides a couple of options for premium assistance for families and children.[279] A less utilized option allows states to pay premiums for individual non–group health insurance plans as well.[280] Collectively, these premium support programs represent a very small portion, 1%, of all Medicaid and CHIP spending.[281]

What is radical about the Arkansas plan is that it tosses Medicaid beneficiaries into a newly created, untested marketplace.[282] And what is politically tantalizing about it is the opportunity for states to expand coverage to low–income, uninsured adults, thus placing the bulk of the funding onus on the federal government, while appearing not to concede their Red State, Obamacare–opposing bona fides. In the words of John Selig, director of the Arkansas Department of Human Services, "There's a feeling around here that if the private market can do something . . . we ought to let them and not create a larger government program."[283] The private insurance approach to Medicaid expansion similarly could make it more palatable to Republicans in other states.[284]

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276 Social Security Act § 1905(a), 42 U.S.C. § 1396d(a) (2012); Margot Sanger–Katz, *The Obama Administration's Super–Expensive, Legally Dubious Medicaid Plan*, Nat'l J. (Mar. 6, 2013), http://www.nationaljournal.com/daily/the–obama–administration–s–super–expensive–legally–dubious–medicaid–plan–20130305 ("[HHS] had to reach back some 25 years into Medicaid law to find the obscure provision that may permit such a move."); Rosenbaum & Sommers, *The Great New Experiment*, *supra* note 15 ("Since 1965, Medicaid has authorized the secretary of health and human services to use federal funds to pay insurance premiums in states that elect such an approach."); Rovner, *supra* note 270 ("The authority to use Medicaid funds to buy insurance has been in the [Medicaid] law since it was first enacted.").

277 *See generally* Joan Alker, Kaiser Comm'n on Medicaid & the Uninsured, The Henry J. Kaiser Family Found. Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act 1 (Mar. 18, 2013), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8422.pdf (describing various states' use of "premium support" options).

278 *See id.* at 4 (describing Medicaid Section 1906 Health Insurance Premium Payment (HIPP) programs).

279 *See id. (*describing CHIPRA Family Coverage Option and Premium Assistance Option).

280 *See id.* Alker also noted that the 2009 GAO Report identified only six states reporting a Medicaid 1905(a) Premium Payment Option program, compared to twenty–nine states with 1906 programs. *Id.* at 6.

281 *Id.*

282 Rosenbaum & Sommers, *The Great New Experiment*, *supra* note 15, at 8.

283 Sandhya Somashekhar, *Arkansas Plan Shows that Health Care Law's Medicaid Expansion Leaves Flexibility for States*, Wash. Post (Mar. 9, 2013), http://articles.washingtonpost.com/2013–03–09/national/37578275_1_medicaid–expansion–insurance–oversight–health–law.

284 *Using Medicaid Dollars for Private Insurance*, Op.–Ed., N.Y Times (Mar. 31, 2012), http://www.nytimes.com/2013/04/01/opinion/using–medicaid–dollars–for–private–insurance.html [hereinafter Using Medicaid Dollars]; Rosenbaum & Sommers, *The Great New Experiment*, *supra*

Despite approval by HHS and passage by the Arkansas legislature, significant questions remain about the viability of the premium support plan. First, the Arkansas approach to coverage may be substantially more expensive for the federal government than traditional Medicaid. The Medicaid program's characteristic, open–ended, non–block–grant funding approach places no cap on the amount of federal dollars available to states to cover Medicaid–eligible beneficiaries.[285] That approach encourages states to spend generously on Medicaid and enroll as many eligible beneficiaries as possible.

Under the Arkansas approach, the federal government may face a much steeper price to cover the Medicaid expansion population. The Congressional Budget Office ("CBO") estimates that it would cost 50% more, or $9000, to buy a private health insurance plan on the exchanges, compared with $6000 to add an individual to traditional Medicaid.[286] The higher cost of private insurance coverage was precisely why Congress rejected that alternative in the ACA itself.[287]

Moreover, it is not clear how the Arkansas arrangement will meet the Medicaid comparability requirement. HHS recently issued proposed regulations, that would require "[t]he cost of purchasing such coverage, including administrative expenditures and the costs of providing wraparound benefits for items and services covered under the Medicaid State plan, but not covered under the individual health plan" to be "comparable to the cost of providing direct coverage under the State plan."[288] The "comparability" term,

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note 15, at 9 ("Ultimately, the most important aspect of premium assistance may be its appeal to conservative politicians who are skeptical of the ACA generally and the Medicaid expansion in particular . . . ."); Somashekhar, *supra* note 283 ("Conservative states might find buying coverage from private insurers more palatable than expanding a government program. Even Democratic–led states might prefer this arrangement because it eliminates some bureaucratic hurdles."); *see* Baker, *supra* note 14 (noting that Iowa has proposed a similar waiver); Johnson, *supra* note 14 ("The Obama administration's approval . . . of Arkansas' plan to expand health coverage for low–income residents under the federal healthcare reform law bodes well for several Republican–led states looking to implement their own alternative models for expanding Medicaid.").

285 *See supra* notes 69, 134–38 and accompanying text (describing Medicaid funding structure and incentives for state spending).

286 Somashekhar, *supra* note 283; *see also* Using Medicaid Dollars, *supra* note 284 ("[P]rivate insurance is almost always more costly than Medicaid."); Rosenbaum & Sommers, *The Great New Experiment*, *supra* note 15, at 9 (citing the same CBO numbers and discussing policymakers' concerns that the premium support model of Medicaid expansion is not financially sustainable).

287 *See supra* sources cited note 23; Sanger–Katz, *supra* note 276 (discussing Senate Finance Committee proposal to rely on exchanges, rather than Medicaid expansion, for low–income uninsureds).

288 Proposed Rule Regarding Medicaid Premiums and Cost Sharing, 78 Fed. Reg. 4594, 4624–25, 4696 (proposed Jan. 22, 2013) (to be codified at 42 C.F.R. § 435.1015(a)(4)), *available at* http://www.gpo.gov/fdsys/pkg/FR–2013–01–22/pdf/2013–00659.pdf; Alker, *supra* note 277, at 5 (describing cost effectiveness standard, expressed as "comparable coverage" but term not defined); Sara Rosenbaum, *Using Medicaid Funds to Buy Qualified Health Plan Coverage for Medicaid Beneficiaries*, Health Reform GPS (Mar. 7, 2013), http://www.healthreformgps.org/resources/using–medicaid–funds–to–buy–qualified–health–plan–coverage–for–medicaid–beneficiaries/ [hereinaf-

however, is not defined, and no range between Medicaid and the private plan is provided.[289] Even if that term receives clearer definition, it will be hard to know whether the exchanges can offer comparably priced plans until they are up and running.

Another question is how Arkansas will ensure that privately insured Medicaid enrollees receive the full range of services and benefits, and for the same cost–sharing obligations, as traditional Medicaid beneficiaries.[290] HHS is clear that the private insurance option is available only if the state covers the expansion population to the same extent as traditional Medicaid beneficiaries.[291] If private plans sold on the exchanges are less comprehensive, the state will have to make up the difference through wraparound coverage.[292] This issue is especially concerning for any children whom the state seeks to cover through the exchanges because Medicaid's EPSDT package of benefits may be substantially more comprehensive than private plans.[293] Also, if the private plans require enrollees to pay higher deductibles and copayments than traditional Medicaid, the state will have to equalize that difference.[294] The logistics of complying with these requirements have yet to be worked out.[295]

Aside from the face–saving political rhetoric, there are other potentially beneficial aspects of the premium support approach to Medicaid expansion. First, the exchanges are intended to create viable markets for individual health insurance that previously did not exist.[296] If the exchanges function as intended, they could generate comparably priced plans to traditional Medicaid coverage. Moreover, to the extent that the Medicaid expansion population is comprised of relatively healthy individuals, a plausible expectation, considering that the group largely includes the working poor, the addition of those new insureds to the exchange risk pools could improve the functioning of the new marketplaces.[297]

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ter Rosenbaum, *Health Reform GPS*].

289 Rosenbaum, *Health Reform GPS*, *supra* note 288.

290 *See* Using Medicaid Dollars, *supra* note 284 ("There is . . . a risk that poor people will end up with fewer benefits and higher cost–sharing on the exchanges despite regulations that should prohibit that.").

291 78 Fed. Reg. at 4624 (defining "cost–effective" as the cost of Medicaid–eligible individuals purchasing plans on the private market); 78 Fed. Reg. at 4696 (to be codified at 42 C.F.R. § 435.1015(a)(2)–(3)).

292 *See* Alker, *supra* note 277, at 8 ("[S]tate would need to provide wraparound coverage to ensure individuals maintain full Medicaid benefits and cost sharing protections."); FAQ, Dec. 10, 2012, *supra* note 153, at 18 ("[P]remium assistance options are subject to the federal standards related to wrap around benefits, cost sharing and cost effectiveness.").

293 *See* Alker, *supra* note 277, at 8–9.

294 *See id*. at 8; *see also* Rosenbaum & Sommers, *The Great New Experiment*, *supra* note 15, at 9.

295 *See* Rosenbaum, *Health Reform GPS*, *supra* note 288.

296 *See* Rovner, *supra* note 270 ("[N]ew Medicaid enrollees will be relatively healthy, relatively young people with relatively low insurance costs . . . [which] could bring premiums down in the exchanges . . . .").

297 *See id*.; *Premium Assistance FAQs*, *supra* note 166, at 2 (suggesting that states may be able

Second, the arrangement could reduce "churn"[298] and support continuity of coverage, especially at the highest end of the Medicaid income eligibility group.[299] Individuals just at or below 138% FPL may experience fluctuations in income levels, for various reasons, including variable work hours. Thus, an individual may be eligible for Medicaid in one month, but ineligible and facing the prospect of purchasing a private plan in another month, when his income is higher.[300] Switching between Medicaid and private plans month–to–month may mean entirely different rosters of providers and covered services, thus creating significant continuity of care problems. If these individuals instead stay in the same exchange–based private insurance plan—with the only difference being whether the government, via Medicaid, or the individual, via self or employer, pays the premium in any given month—these problems can be reduced or avoided.[301]

Third, the private insurance approach to Medicaid expansion could increase access to care.[302] Medicaid is perennially challenged to enlist sufficient participating providers due to low rates of reimbursement.[303] Private insurance plans typically reimburse providers at a higher rate and have better participation.[304] Accordingly, Medicaid enrollees covered through private plans may have a larger network of providers from which to choose.[305] Other states and federal authorities will be watching Arkansas carefully to gauge the likely success of the premium support approach to Medicaid expansion.[306]

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to quantify cost effectiveness of a premium support option, for example, by showing "increased competition in Marketplaces given the additional enrollees due to premium assistance").

298 Rovner, *supra* note 270 (explaining that churning occurs when an individual's income is near the income threshold for Medicaid eligibility, meaning that in some months the individual may qualify for Medicaid while in other months he may not and will be pushed back into the private insurance market); Rosenbaum & Sommers, *The Great New Experiment*, *supra* note 15, at 8 (citing Sommers & Epstein, *supra* note 154, at 469–99) ("[L]ow–income adults experience so much income fluctuation that 28 million annually could 'churn' across the Medicaid–exchange divide . . . .")

299 Alker, *supra* note 277, at 8.

300 *See* Rosenbaum & Sommers, *The Great New Experiment*, *supra* note 15, at 8; FAQ, Dec. 10, 2012, *supra* note 153 at 17 (explaining how states can use premium assistance to promote continuity of care when individuals move among coverage options).

301 Rosenbaum & Sommers, *The Great New Experiment*, *supra* note 15, at 8–9; Rovner, *supra* note 270 (discussing reduced churning and improved continuity).

302 Rosenbaum & Sommers, *The Great New Experiment*, *supra* note 15, at 9.

303 *See* Rovner, *supra* note 270.

304 *See id.* (quoting Austin Frakt, health economist at Boston University) ("'One of the basic critiques of the Medicaid program is they pay providers too little and that's why too few of them participate' . . . .").

305 Using Medicaid Dollars, *supra* note 284; Alker, *supra* note 277, at 8.

306 For further examination of Arkansas's strategy, see Sidney D. Watson, *Medicaid, Marketplaces, and Premium Assistance: What Is at Stake in Arkansas? The Perils and Pitfalls of Medicaid Expansion Through Marketplace Premium Assistance,* 102 Ky. L. J. 471 (2014).

3. Michigan.—In Michigan, Governor Rick Snyder was the sixth Red State governor to come out in support of Medicaid expansion.[307] Governor Snyder, a Republican, cited a host of reasons, including reducing the state's uninsured rate by 46%, bringing in substantial federal funding, increasing access to primary care providers, reducing the burden on hospitals and small businesses, saving tax dollars, and "put[ting] Michigan, rather than Washington, in the driver's seat in terms of [health reform] implementation."[308] At the end of the 2013 legislative session, the Michigan legislature was unable to agree on expansion. Finally, in September 2013, Governor Snyder became the third Republican governor of a state with a Republican–controlled legislature to sign Medicaid expansion into law.[309]

Governor Snyder faced an uphill battle to gain the support of the state legislature. He announced his support for Medicaid expansion as part of his state budget proposal on February 6, 2013.[310] He noted that Medicaid expansion was estimated to reduce uncompensated care costs by $351 million over the next decade, bring $20 billion in additional federal funds to the state by 2023, and save the state $1.2 billion between 2013 and 2020.[311]

Snyder's position on Medicaid expansion found support among medical groups, such as the Michigan Health and Hospital Association, as well as traditionally conservative commerce groups, such as the Small Business Administration[312] and the Michigan Chamber of Commerce.[313] Both constituencies noted that the ACA's cuts in DSH funding for uncompensated care would increase costs for medical providers and businesses paying health

307 *See* Advisory Bd. Daily Briefing, *supra* note 4 (summarizing states' positions on Medicaid expansion).

308 Press Release, Governor Rick Snyder, *Snyder Calls for Medicaid Expansion to Improve Health, Save Money; Greater Access to Care, Lower Business Costs Among Benefits* (Feb. 6, 2013), http://www.michigan.gov/snyder/0,4668,7–277–57577_57657–294479—,00.html [hereinafter Snyder Press Release].

309 *See* H.R. 4714, 97th Leg., Reg. Sess. (Mich. 2013), *available at* http://www.legislature.mi.gov/documents/2013–2014/publicact/pdf/2013–PA–0107.pdf; Jonathan Oosting, *Michigan Gov. Rick Snyder Signs Historic Medicaid Plan into Law: This Is About "Family" Not "Politics"*, Mlive.com (Sept. 16, 2013),) http://www.mlive.com/politics/index.ssf/2013/09/michigan_gov_rick_snyder_signs_6.html (describing the "Healthy Michigan" plan). The other two states are Arizona and North Dakota. *Gov. Snyder Signs Medicaid Expansion Bill*, CBS Detroit (Sept. 16, 2013), http://detroit.cbslocal.com/2013/09/16/gov–snyder–to–sign–medicaid–expansion–bill/.

310 *See* Mary Wisniewski, *Michigan Republican Governor Snyder Backs Medicaid Expansion*, Reuters (Feb. 6, 2013, 4:41 PM), http://www.reuters.com/article/2013/02/06/us–usa–healthcare–medicaid–idUSBRE91519720130206.

311 Snyder Press Release, *supra* note 308. The figure for savings from uncompensated care came from a Kaiser Family Foundation study on the state–by–state effects of the Affordable Care Act. Holahan et al., *supra* note 174, at 9.

312 Wisniewski, *supra* note 310.

313 Mark Brush, *One More Republican Calls for Medicaid Expansion in Michigan*, Mich. Radio (July 8, 2013, 12:06 PM), http://www.michiganradio.org/post/one–more–republican–calls–medicaid–expansion–michigan.

insurance premiums for their workers, due to increased cost shifting.[314]

Michigan's House Speaker, however, immediately expressed uncertainty about expanding Medicaid, arguing that "[t]he federal government has a history of working with states to start long–term projects while providing only short–term funding, and then sticking state taxpayers with the future financial liability that program creates."[315] With this objection in mind, Governor Snyder proposed that half of all savings from the Medicaid expansion should be placed in a fund to offset the increased Medicaid costs after 2020, should the federal government lower payments from the levels promised in the ACA.[316]

Although the legislature's research confirmed the minimal budgetary impact of Medicaid expansion, Governor's Snyder's budget was not approved as proposed. The Senate's Fiscal Agency concluded that "[e]ven in the worst case scenario, the proposed expansion of Medicaid would result in large . . . savings during the first five years, with net . . . costs . . . not exceeding savings until the 10th year of the expansion."[317] In March, a House subcommittee removed over $180 million that the Department of Community Health would have received if the state approved Medicaid expansion.[318] The vote on Medicaid expansion fell along party lines.[319] Republicans in the legislature repeated fears that "federal money could not be guaranteed."[320] The budget for the Department of Community Health was eventually approved, but without the Medicaid expansion, by a slim margin.[321] This essentially ended the chance for Medicaid expansion to be approved through the budget process. Governor Snyder signed the budget on June 13, 2013, without a provision for Medicaid expansion.[322]

Meanwhile, House Republicans were working on a modified form of

314 Scott Davis, *Clock Ticking on Michigan Medicaid Expansion*, Lansing State J. July 7, 2013, at A1.

315 Kathleen Gray & Robin Erb, *On Medicaid Expansion, Michigan GOP Gov. Snyder Will Need Legislature's Support*, Governing (Feb. 7, 2013), http://www.governing.com/news/state/mct–snyder–announces–support–for–medicaid–expansion.html (internal quotation marks omitted) (quoting House Speaker Jase Bolger).

316 *See* Snyder Press Release, *supra* note 308.

317 Steve Angelotti, Senate Fiscal Agency, *Fiscal Analysis of Governor Snyder's Medicaid Expansion Proposal* 14 (2013), *available at* http://www.senate.michigan.gov/sfa/Publications/Issues/MedicaidExpansion/MedicaidExpansionProposal.pdf.

318 Kathleen Gray, *House Subcommittee Passes Health Budget Without Gov. Snyder's Proposed Medicaid Expansion*, Detroit Free Press (Mar. 20, 2013, 12:27 PM), http://www.freep.com/article/20130320/NEWS15/130320036/House–subcommitee–passes–health–budget–without–Gov–Snyder–s–proposed–Medicad–expansion.

319 *Id.*

320 *Id.*

321 Kathleen Gray, *Medicaid Expansion Takes Another Hit with Vote in State Senate*, Detroit Free Press (May 16, 2013, 5:57 PM), http://www.freep.com/article/20130516/NEWS06/305160161/medicaid–affordable–care–act–sentate–low–income.

322 Paul Egan, *Gov. Snyder Signs 2014 State Budget, Says It's 'Very Solid,'* Detroit Free Press (June 14, 2013, 12:12 AM), http://www.freep.com/article/20130613/NEWS06/306130100/Gov–Snyder–signs–2014–state–budget–says–s–very–solid.

Medicaid expansion. This bill would expand Medicaid for only four years, rather than the full seven years for which the ACA expressly provides funding.[323] More significantly, the bill would require new Medicaid beneficiaries with incomes above the federal poverty level to contribute 5% of their annual income to their health care. This copayment would be increased to 7% if a beneficiary remained covered under Medicaid for longer than four years.[324] The required financial contribution injects a stronger element of individual responsibility and cost sharing than traditional Medicaid imposes on beneficiaries. Because the proposal departs significantly from statutory limits on Medicaid cost–sharing, it would require federal approval.[325]

This alternate approach to Medicaid expansion passed the Michigan State House, but stalled in the Senate during the regular session.[326] The Senate Majority Leader, Randy Richardville, refused to take the bill to a vote because he was not confident that a super–majority of Republicans would support it.[327] Richardville insisted that his maneuver saved the governor from certain political defeat. He rejected Governor Snyder's criticism that the move was a "vacation" instead of a "vote."[328] Instead, Richardville appointed a Senate work group, consisting of six Republicans and two Democrats, to consider alternatives during the legislative recess.[329]

The Senate narrowly passed a slightly modified version of the House bill on August 27, 2013.[330] The Senate amendments require the state to seek two waivers from the federal government. One waiver establishes health savings accounts for non–disabled adults with incomes between 100% and 133% of the federal poverty level and requires such individuals to pay up to 5% of their yearly income as co–pays.[331] The second waiver would require the non–disabled adults who are covered under state Medicaid for 48 months to either (1) accept premium tax assistance credits to purchase insurance on the health insurance

323 *See* Karen Bouffard, *Medicaid Expansion Heads to Senate*, Detroit News, June 14, 2013, at A12, *available at* 2013 WLNR 14612990.

324 *Id.*

325 *Id.*

326 *Id.*

327 *See* Chad Livengood, *GOP Rebuffs Gov's Agenda*, Detroit News, June 22, 2013, at A5, *available at* 2013 WLNR 15271667; *see also* Davis, *supra* note 314.

328 *See* Livengood, *supra* note 327.

329 *See* Kathleen Gray, *Senate Majority Leader Appoints Two Democrats to Medicaid Expansion Group*, Detroit Free Press (Jul. 3, 2013, 10:56 AM), http://www.freep.com/article/20130702/NEWS06/307020089/Senate–Majority–Leader–appoints–two–Democrats–to–Medicaid–expansion–work–group.

330 H.B. 4714, 97th Leg., Reg. Sess. (Mich. 2013), *available at* http://www.legislature.mi.gov/documents/2013–2014/publicact/pdf/2013–PA–0107.pdf; *see also* Kathleen Gray, *Medicaid Expansion Passes After Heating Politicking; 470,000 More Michiganders to Get Coverage*, Detroit Free Press (Aug. 27, 2013, 11:37 PM), http://www.freep.com/article/20130827/NEWS06/308270106/Medicaid–expansion–michigan–vote–affordable–care–act.

331 Social Welfare Act, H.B. 4714, 97th Leg. § 105d(1)(e) (2013).

exchanges or (2) pay co–pays of up to 7% of their income.[332] With great fanfare, Governor Snyder signed the legislation into law on September 16, 2013, declaring: "The right answer is not to talk about politics, but to talk about our family of 10 million people."[333] The Medicaid expansion will not be effective until the first waiver is passed,[334] and it will be invalidated if both waivers are not approved.[335]

Governor Snyder's early, vocal support of Medicaid expansion cost him support among many Tea Party supporters. They criticized the governor for inviting Secretary Sebelius to Michigan to rally support for Medicaid expansion, calling the Secretary "a representative of the most destructive American President of our history as a nation."[336] Tea Party activists have also pushed for the replacement of the lieutenant governor with "a conservative option."[337] Many Michigan Republicans remained reluctant to support any version of Medicaid expansion, fearing challenges from the Tea Party.[338] One of the Senate work group members proposed a radical, market–based approach for the low–income uninsured that would replace Medicaid expansion with catastrophic coverage purchased through the private exchange market,[339] similar to the proposal under consideration in Florida.[340]

The situation in Michigan demonstrates the persistent sway of Tea Party forces even in the face of clear financial benefit to the state. A coalition of Democratic and Republican supporters is essential for Medicaid expansion, but cannot coalesce as long as Republican lawmakers fear political retribution and refuse to cross the Red State line. Governor Snyder advocated Medicaid expansion, citing a host of accepted reasons and receiving backing from key business and health care constituents. As he signed the law, he sounded clear morality tones, dismissing political obstructionism. He spoke of "our family" of uninsured residents.[341] He added, "'[F]or the sweet love of God, let's

332 H.B. 4714 § 105d(20).

333 Oosting, *supra* note 309*; see also* Kathleen Gray et al., *Snyder Signs Medicaid Expansion into Law*, Lansing State J. Sept. 17, 2013, at A3, *available at* 2013 WLNR 23191797.

334 H.B. 4714, 97th Leg. § 105d(1)(a) (2013) ("The department of community health shall not begin enrollment of individuals eligible under this subdivision until January 1, 2014 or until the waiver requested in this subsection is approved by the United States department of health and human services . . . ."); Oosting, *supra* note 309.

335 H.B. 4714 § 105d(26).

336 Kathleen Gray, *Tea Party Group Threatens to Pull Support of Gov. Rick Snyder Over Proposed Medicaid Expansion*, Detroit Free Press (June 11, 2013, 7:16 PM), http://www.freep.com/article/20130611/NEWS06/306110090/Medicaid–tea–party–governor–rick–snyder–re–election.

337 Tim Skubick, *Tea Party May Push to Replace Lt. Gov. Brian Calley, But Expect a Fight*, Mlive.com (Jul. 21, 2013, 8:48 AM), http://www.mlive.com/politics/index.ssf/2013/07/tim_skubick_tea_party_rick_sny.html.

338 Davis, *supra* note 314.

339 *Id.* (discussing Senator Bruce Caswell's proposal).

340 *See infra* notes 360–83 (discussing Florida's CARE plan).

341 Oosting, *supra* note 309.

understand that we have to work together to make our government work,' he said to applause. 'Politics is a sport to many Americans, but it should not be a blood sport. We are all in this together.'"[342] Whether Governor Snyder's plea for civility and morality will appeal to other Red States remains dubious.

4. Florida.—More surprising than Governor Snyder's support for Medicaid expansion was the support from Florida's Republican governor, Rick Scott.[343] In February 2013, Governor Scott became the seventh Red State governor to announce that the state would expand Medicaid.[344] Governor Scott had been one of the ACA's most vocal critics, and his state was the lead plaintiff in *NFIB v. Sebelius,* seeking to block both the individual mandate and Medicaid expansion. Florida also had declined to support ACA implementation by establishing a state–based health insurance exchange, and, immediately following the Supreme Court's decision in June 2012, Governor Scott announced that the state would opt out of Medicaid expansion as well.[345]

In explaining his about–face, Scott cited both the generous federal funding and double taxation rationales. [346] Accordingly, he supported a three–year expansion, limited to the time period during which the federal government would fully fund the expansion population's coverage. Conceding that there were "no perfect options," Scott summed up the situation: "[O]ur options are either having Floridians pay to fund this program in other states while denying health care to our citizens, . . . or using federal funding to help some of the poorest in our state with the Medicaid program as we explore other health care reforms."[347] He also noted that his mother's recent death and her struggle to raise five children on limited income influenced his decision.[348]

Governor Scott timed his announcement supporting Medicaid expansion with another announcement regarding the state's existing Medicaid program.[349] The language of the press release was emblematic of the Red State Narrative, suggesting that that state and federal authorities had struck some sort of deal that could be chalked up as a victory for the state. Scott stressed that "after months of negotiations with HHS," Florida had "won" two waivers "granting

342 *Id.*

343 *See* Goodnough & Pear, *supra* note 205 ("Mr. Scott's support for expanding Medicaid is particularly significant . . . and surprising. . . . [H]e has been among the most strident critics of the health care law, and his opposition to it was a cornerstone of his 2010 campaign for governor.").

344 *See* Lizette Alvarez, *In Reversal, Florida to Take Health Law's Medicaid Expansion*, N.Y. Times, Feb. 20, 2013, at A13, *available at* http://www.nytimes.com/2013/02/21/us/in–reversal–florida–says–it–will–expand–medicaid–program.html.

345 *See id.*

346 *See id.*

347 *Id.* (internal quotation marks omitted).

348 *Id.*

349 *See* Jason Millman, *Florida Gets OK for Medicaid Managed Care*, Politico (June 17, 2013, 5:06 AM), http://www.politico.com/story/2013/06/florida–medicaid–managed–care–rick–scott–92863.html.

additional flexibilities" for the state's Medicaid program.[350] The first waiver related to the long–term care program, and the second related to the Statewide Medicaid Managed Care Program.[351] Scott emphasized that the Secretary's approval "makes us two–for–two in our request for Medicaid flexibilities."[352] In reality, such waiver requests are common and easily granted to states under well–established Medicaid amendments.[353] The waivers also were not newly devised by Governor Scott, but expanded Medicaid demonstration projects initiated under prior Governor Jeb Bush.[354] Scott's announcement, however, allowed him to frame his support for Medicaid expansion not as rolling over to federal authorities but as part of a strategically negotiated deal.

Even with the governor's support for expansion, the matter was still subject to approval by Florida's Republican–controlled legislature.[355] Two Republican House Representatives, Will Weatherford and Richard Corcoran, proposed a dramatically different plan that would be entirely state–funded and free–market–based.[356] The sponsors listed seven reasons for rejecting Medicaid expansion, many of which are familiar from the NEJM survey, including that Medicaid is: (1) a failing program, (2) harms others (especially Medicare recipients, a significant demographic in Florida given the retiree population) by limiting access to providers, (3) ties up state resources for education and other initiatives, (4) is characterized by unpredictable costs, (5) presents the possibility of the federal government reneging on its generous funding promise, (6) drives up charity care and private insurance costs through cost–shifting, and (7) increases dependency on government services.[357]

The proposal would retain Florida's existing, limited Medicaid expansion for low–income parents; those with jobs are eligible for Medicaid up to 56% FPL, and those without are eligible up to 22% FPL.[358] Individuals with incomes between 138% and 100% FPL would be eligible for federal subsidies

350 Press Release, Rick Scott, Governor Scott: Florida Wins 2nd Medicaid Waiver Granting Flexibilities, Rick Scott (Feb. 20, 2013), http://www.flgov.com/2013/02/20/governor–scott–florida–wins–2nd–medicaid–waiver–granting–flexibilities/.

351 *Id.*

352 *Id.*

353 *See supra* notes 107–14 (discussing Medicaid waiver and managed care options).

354 *See* Millman, *supra* note 349.

355 Goodnough & Pear, *supra* note 205 (noting that Republican leaders "expressed misgivings").

356 Avik Roy, *Florida's Innovative, Consumer–Driven Replacement for Obamacare's Medicaid Expansion*, Forbes (Apr. 12, 2013, 10:45 AM), http://www.forbes.com/sites/theapothecary/2013/04/12/floridas–innovative–consumer–driven–replacement–for–obamacares–medicaid–expansion/ [hereinafter Roy, April].

357 Fla. House Majority Office, Florida Health Choices Plus 3, 7–24 (2013), *available at* http://www.myfloridahouse.gov/Handlers/LeagisDocumentRetriever.ashx?Leaf=housecontent/HouseMajorityOffice/Lists/Other%20Items/Attachments/6/Florida_Heath_Choices_Plus.pdf&Area=House (discussing seven reasons in detail); *see also* Roy, April, *supra* note 356 (summarizing opponents' arguments).

358 *See* Roy, April, *supra* note 356.

on the new health insurance exchanges, as provided in the ACA.[359] Other low–income, uninsured individuals would be offered a "CARE" (Contribution Amount for Reasonable Expenses) plan through the existing, pre–ACA Florida Health Choices program.[360] Florida Health Choices is essentially a private–market clearinghouse offering a range of insurance products, ranging from high–deductible catastrophic health plans to wraparound concierge medical plans.[361] Although operating somewhat similarly to the ACA's health insurance exchanges, Florida Health Choices is not subject to the exchange mandates and offers plans that would not comply with the new federal requirements.[362] Participants would receive $2000 per year from the Florida government and would be required to contribute $25 per month of their own income.[363] There are also variable work requirements for participants, depending on worker age and dependents, ranging from 20 to 35 hours per week, similar to old federal welfare–to–work programs.[364]

The CARE plan effectively amounts to a $2300 annual voucher or health savings account, which could be spent on plans in Florida Health Choices, or to pay out–of–pocket medical expenses.[365] The proposal is similar to John McCain's and Paul Ryan's proposals for federal health reform.[366] The amount would roll over, meaning that participants would not lose the money if they did not end up using it in any given year.[367] Employers could also use the program to make contributions for the benefit of their employees.[368] Among other advantages, the sponsors urge that the plan does not suffer from Medicaid's unpredictable costs, driven in large part by its characteristic defined benefit plan.[369] CARE, by contrast, is a defined contribution plan.[370] Moreover, it is

359 *Id.*

360 *Id.*; Anthony Brino, *Florida Democrats, Governor Balk at GOP Medicaid Alternative*, Healthcare Payer News (Mar. 16, 2013), http://www.healthcarepayernews.com/content/florida–democrats–governor–balk–gop–medicaid–alternative.

361 Avik Roy, *Florida Senate Republicans Vote to Expand Obamacare and Medicaid, Rejecting House's Free–Market Alternative*, Forbes (May 1, 2013, 2:45 AM), http://www.forbes.com/sites/theapothecary/2013/05/01/florida–senate–republicans–vote–to–expand–obamacare–and–medicaid–rejecting–houses–free–market–alternative/ [hereinafter Roy, May].

362 *See* Roy, April, *supra* note 356.

363 *Id.*

364 *Id.*; *see also* Florida Health Choices Plus, *supra* note 357, at 37–38 (describing "[r]easonable work requirements for recipients of taxpayer help").

365 Roy, April, *supra* note 356.

366 Roy, May, *supra* note 361.

367 Roy, April, *supra* note 356.

368 *Id.* (noting that employers could also use the CARE system to make defined contributions to their employees); *see also* Brino, *supra* note 360 ("Employers could also used [sic]use the account–based system to make defined contributions to their workers—who, in retail and service industries . . . face an uncertain future of health coverage as businesses figure out whether to 'pay or play.'").

369 *See* Roy, April, *supra* note 356.

370 *Id.*

fully state controlled, allows consumers to actively direct their health care, and relies on the free market rather than government assistance.[371]

The CARE plan, however, would cover substantially fewer of Florida's current 3.7 million uninsured individuals than Medicaid expansion.[372] Medicaid expansion is predicted to cover roughly one million currently uninsured Floridians,[373] while the CARE plan would cover just 55% percent of that population.[374] Other estimates are even lower, suggesting that CARE would cover only 115,000 people.[375] Bill sponsors note, however, that Medicaid expansion would ultimately cost the state $1.3 billion, while their plan would cost a mere $237 million.[376] The sponsors justified fractional coverage and the private–market model by noting that only 28% of uninsured Floridians are below the federal poverty level, most are in good health, most are only temporarily uninsured, and only a small minority, 12%, used more than $2000 of health care in the previous year.[377] Accordingly, CARE operates as a "bridge" between gaps in insurance rather than fostering "permanent dependency."[378]

The CARE plan passed the Florida House in April, but Senate Republicans rejected it, opting instead to support Medicaid expansion modeled on the Statewide Medicaid Managed Care waiver that Governor Scott had touted.[379] Echoing the Governor's statements, Senate sponsors played up the market–based elements of Medicaid expansion, including the role of private insurers and cost–sharing requirements.[380] But again, the arrangement would not be dramatically different than private insurance approaches to Medicaid coverage long allowed under previous Medicaid amendments.[381] Governor Scott offered his support for the Senate's "Healthy Florida" plan, again raising the double–

371 *See id.*

372 Brino, *supra* note 360 ("The plan . . . would cover about 115,000 uninsured Floridians—a fraction of the state's estimated 3.7 million uninsured and far fewer than the 186,000 who would be covered under ACA–expanded eligibility.").

373 Brino, *supra* note 360 (reporting that 816,000 are to be covered under Medicaid expansion); Sarah Kliff, *Florida Rejects Medicaid Expansion, Leaves 1 Million Uninsured*, Wash. Post Wonkblog (May 5, 2013), http://www.washingtonpost.com/blogs/wonkblog/wp/2013/05/05/florida–rejects–medicaid–expansion–leaves–1–3–million–uninsured/ (reporting that approximately 1.3 million Floridians were expected to gain coverage through Medicaid expansion); Roy, April, *supra* note 356 (reporting that 900,000 Floridians would gain coverage through Medicaid expansion).

374 Roy, April, *supra* note 356.

375 Brino, *supra* note 360.

376 Roy, April, *supra* note 356.

377 Brino, *supra* note 360 ("Only 25 percent of Florida's uninsured leave below the poverty line . . . ."); Florida Health Choices Plus, *supra* note 357, at 26–30 ("Only 1 in 4 uninsured Floridians live in poverty."); Roy, April, *supra* note 356 ("It turns out that only 28 percent of uninsured Floridians live below the poverty line . . . .").

378 Roy, April, *supra* note 356.

379 Roy, May, *supra* note 361.

380 *Id.*

381 *See supra* notes 107–26 and accompanying text (describing flexibility allowed under Medicaid program).

taxation argument.[382] The 2013 legislative session ended without resolution of the Medicaid expansion issue or adoption of the House alternative approach.[383]

Despite the failure to enact Medicaid expansion legislation, the experience in Florida is useful for developing the Red State Narrative. First, Governor Scott's support for expansion embodied the economics "plus" trend that has brought other Red State governors along. The "plus" being some negotiated victory for the state and insistence that a significant element of state autonomy be retained. Whether a core market–based element to the expansion plan is necessary for passage remains to be seen. Even with the governor's negotiated federalism frame and Senate leaders' emphasis on the private, managed care delivery model, expansion was still not yet politically palatable.

IV. The Red State Narrative

Drawing from the above case studies, five key elements of the Red State Narrative can be identified: First, recognizing the changes that the ACA made to the Medicaid program are not new or constitutionally significant; second, acknowledging the nearly irrefutable economic analyses demonstrating the net benefit to expansion states; third, identifying a politically compelling constituency to push for expansion; fourth, heralding at least the appearance of a significant concession from the federal government; and, fifth, retaining elements of a private health insurance market within the expansion model.

The first element in framing the Red State Narrative is to emphasize, as the first Parts of this Article did,[384] that what is being asked of states by way of the ACA's Medicaid expansion is not dramatically different from prior amendments to the Medicaid statute. If state lawmakers opposing expansion can come to recognize this fact, they may be able to back off of some of the entrenched Tea Party rhetoric that drove the ACA litigation and continues to drive repeal efforts and resistance to implementation. These entrenched political views temporarily stalled expansion efforts in Michigan, despite strong support from the state's Republican governor.[385]

Throughout the ACA litigation, there was little question that Medicaid

382 Brino, *supra* note 360 (quoting Governor Scott) ("'[The House plan] will cost Florida taxpayers on top of what they are already taxed under the President's new healthcare law [and] would be a double–hit to state taxpayers.'"); Roy, April, *supra* note 356 (alteration in original) (quoting same, suggesting that Scott "blasted" the House proposal and noting that it "spends *far less* state money than Obamacare does"); Roy, May, *supra* note 361 (quoting same, but urging that "[Governor] "Scott is factually incorrect," noting cost of Medicaid expansion compared to cost of House proposal).

383 Kliff, *supra* note 373; James M. Taylor, *Florida House Rejects Medicaid Expansion, Outcome in Doubt*, Heartlander (July 2, 2013), http://news.heartland.org/newspaper–article/2013/07/02/florida–house–rejects–medicaid–expansion–outcome–doubt.

384 *See supra* Parts I, II.

385 *See supra* Part III.C.3.

expansion was a constitutional exercise of congressional spending power,[386] just as challenges to prior Medicaid amendments or similar conditional spending programs have consistently been upheld.[387] Litigants in the *Health Care Cases* had not even prepared briefs on the "what if" question, should the Court strike down the Medicaid provisions.[388] Red State lawmakers should redirect their objections to other aspects of federal health reform and recognize that this part of the law, at least, does not threaten their federalism principles in any serious way. If they could recognize that Medicaid expansion offers considerable flexibility and that federal funding would address vexing state budgetary and public policy challenges, they might be willing to come around.

Repeatedly since its enactment, Medicaid has been expanded to new groups of beneficiaries.[389] Those expansions imposed significant new requirements on states, admittedly not always without protest. Like the ACA, they represented evolving policy priorities addressing which individuals are appropriate objects of government assistance.[390] In passing the ACA, Congress eventually agreed that everyone below 138% FPL, regardless of categorical status of age, disability, parenthood, or employment, deserved government assistance. That change to the Medicaid program is remarkable from a health policy—but not a constitutional—perspective.[391] The arguments in *NFIB* resonated not because

386 *See* Florida *ex rel.* Attorney Gen. v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235, 1263–68 (11th Cir. 2011) (holding Medicaid expansion was within congressional spending power); Florida *ex rel.* Bondi v. U.S. Dep't of Health & Human Servs., 780 F. Supp. 2d 1256, 1267 (N.D. Fla. 2011), *aff'd in part, rev'd in part*, 648 F.3d 1235 (11th Cir. 2011) ("[T]here is simply no support for the state plaintiffs' coercion argument in existing case law."); Huberfeld et al., *supra* note 6, at 30, 31–32 (describing the Eleventh Circuit's reasoning and noting that no lower court had declared the Medicaid expansion unconstitutional).

387 *See, e.g.*, Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 22 (1981) (finding that the Developmentally Disabled Assistance and Bill of Rights Act created shared responsibilities between the federal and state governments); Steward Mach. Co. v. Davis, 301 U.S. 548, 593–98 (1937) (rejecting the claim that the Social Security Act's tax collection and unemployment benefits distribution infringed on state sovereignty); California v. United States, 104 F.3d 1086, 1092 (9th Cir. 1997) (upholding an additional Medicaid requirement to cover emergency medical care to illegal immigrants); Oklahoma v. Schweiker, 655 F.2d 401, 416–17 (D.C. Cir. 1981) (holding that the pass–through provision of the Social Security Act was a "conventional and appropriate" use of congressional power under the Spending Clause). In Texas v. Leavitt, the plaintiffs requested that the Supreme Court assert original jurisdiction to review the Medicare Part D clawback, which required states to pay a portion of the new Medicare prescription–drug benefit. Plaintiffs' Reply Brief at 1, Texas v. Leavitt, 547 U.S. 1204 (2006) (No. 135). The Supreme Court was unwilling to hear the challenge, denying the states' petition for original jurisdiction. *Texas*, 547 U.S. 1204 (mem.).

388 *See* Huberfeld et al., *supra* note 6, at 35 (citations omitted) ("Almost as an afterthought, the United States pointed out the 'separability' clause in § 1303, providing that should any provision of the Act be declared invalid, the remainder should remain unaffected.").

389 *See supra* Part II.C (describing prior amendments to eligibility).

390 *See supra* Part II.

391 *But see* NFIB v. Sebelius, 132 S. Ct. 2566, 2606 (2012) ("Previous amendments to Medicaid eligibility merely altered and expanded the boundaries of these categories. Under the Affordable Care Act, Medicaid is transformed into a program to meet the health care needs of the entire non-

there was something so different about what Congress had done this time around, but because the political climate around states' rights and principles of federalism was so ripe. As previously noted, *NFIB* can be viewed as the completion of Justice Rehnquist's federalism revolution.[392]

In addition, the flexibility afforded to states in the benefits package offered to new Medicaid beneficiaries under the ACA should be understood as consistent with the evolution of the Medicaid program and respectful of state autonomy under the Tenth Amendment. Far from a federal cram–down, the ACA allows states to custom–design, within certain parameters, the benefits package for the expansion population. States may offer the traditional Medicaid package, a benchmark or benchmark–equivalent package, a managed care plan, or any other novel approach that the federal government approves under its long–standing waiver authority.[393] The Court's opinion erroneously suggests that the ACA was the first introduction of a distinct Medicaid benefits package.[394] More importantly, the opinion relies on the fact of this variation as proof that the ACA's Medicaid amendments exceed Congress's conditional spending power. Had the Court better understood the history of the Medicaid program and the actual operation of the ACA's approach to Medicaid benefits,[395] it might have realized that the flexible arrangement promoted, rather than destroyed, federalism principles.

The Court's last reason for characterizing Medicaid expansion as different in kind was that it provides more generous federal financing for the new population of beneficiaries than for individuals already eligible for the program.[396] But this difference, too, should not render the mandatory operation of the statute unconstitutional. The federal government's payment of 100% of expansion costs for three years, and 90% of expansion costs in perpetuity,[397] does not coerce states. Instead, the arrangement puts near total federal financial support for expanding coverage through states' established public benefits channels. Indeed, as several states' governors noted, the infusion of federal dollars merely supports health reforms they had already enacted and, in many cases, will relieve them of the costs of doing so.[398]

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elderly population with income below 133 percent of the poverty level.").

392 *See* Huberfeld et al., *supra* note 6, at 47–50.

393 *See supra* notes 107–26 (discussing Medicaid waivers and flexibility).

394 *NFIB*, 132 S. Ct. at 2606 ("The conditions on use of the different funds are also distinct. Congress mandated that newly eligible persons receive a level of coverage that is less comprehensive than the traditional Medicaid benefit package.").

395 *See supra* notes 107–26 (describing history of Medicaid coverage amendments).

396 *NFIB*, 132 S. Ct. at 2606 ("Congress created a separate funding provision to cover the costs of providing services to any person made newly eligible by the expansion.").

397 42 U.S.C. § 1396d(y)(1) (2012).

398 *See, e.g.*, Sommers & Epstein, *supra* note 154, at 498 tbl.2 (alteration in original) ("Many governors who support the Medicaid expansion argued that it builds on previous coverage expansions in their states and that it would actually save their states money by replacing local dollars with federal funds. Peter Shumlin (D–VT) explained that opponents 'are acting like we are not already

Even for states that had not voluntarily extended some benefits to the new Medicaid population, it is still an undeniably better deal to let the federal government pay the lion's share of the costs, rather than designing and funding a novel state solution. States, of course, may choose to do nothing—to opt out of Medicaid expansion and to decline to offer any form of state assistance to the uninsured. But the inevitable costs to health care providers of providing uncompensated care and to employers paying higher insurance premiums as a result of cost shifting will adversely impact states' economies and commerce.[399]

Accordingly, the second key element of the Red State Narrative is the economic argument. Medicaid expansion, by almost all accounts, is an extraordinarily good deal for states. Think tanks, consumer advocacy groups, health policy institutes, chambers of commerce, and others have prepared numerous analyses demonstrating the net economic benefit for states, which are hard to refute.[400] States counter that even a one or two percent increase in state Medicaid costs is unsustainable, even if that increase represents a very small sum relative to the large infusion of new federal dollars.[401] But that argument must be considered against the harder to quantify costs, described in the previous paragraph, for which states may not have budgeted. In tight budget times, it is hard to understand how states can walk away from a significant pot of federal funding. Moreover, states should recognize, as Florida's Governor Scott did, that refusing to take federal Medicaid expansion dollars only hurts their citizens, who will continue to pay federal taxes toward Medicaid expansion being undertaken in other states but being refused by their own.

The third element of the Red State Narrative is voter pressure from a politically compelling constituency. Arizona provides the clearest examples of this dynamic at work. There, a Tea Party stalwart governor was willing to retract prior strongly voiced objections to federal health care reform and cross party lines to embrace Medicaid expansion because it was favored by the state's strong Latino constituency. Similar voter dynamics drove Red State governors in other Southwestern states, namely Nevada and New Mexico, to accept Medicaid expansion.

Whether these governors' support for the ACA's Medicaid amendment expresses evolved notions of the "deserving poor" or simply the politics of voter demographics, the outcome is the same. Nevada's governor, for one, made public statements suggesting the former. Among other reasons for supporting expansion, Governor Martinez noted an "obligation to provide an adequate

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paying for this. What we're proposing . . . is to pay less for something that we are already paying for right now.'").

399 *See supra* notes 221–31 (citing studies estimating impact of Medicaid expansion on state economies).

400 *See supra* notes 202–216, 226–28 (citing various studies).

401 *See supra* notes 173–77, 182–86 (citing, for example, Georgia's 2.5 to 4.5% budget increase to support expansion).

level of basic health care services for the most in need of our state."[402] The suggestion that individuals other than the elderly, disabled, children, pregnant women, and some parents might be included among those "most in need" is the very point that Justice Ginsburg made in rebuttal to Chief Justice Roberts's suggestion about the fundamental change wrought by the ACA's Medicaid expansion.[403]

While Latino voters in the Southwest may be a region–specific constituency, similar campaigns could be mounted in other parts of the country. Particularly in the deeply resistant South, African–American voters have indicated strong support for Medicaid expansion[404] and may represent a significant voter demographic. Significantly, convincing reasons for supporting Medicaid expansion among this group include both economic and morality arguments.[405] Those who opposed Medicaid expansion are more likely to be persuaded if it is good for business and the state's economy.[406] The majority of those who already supported expansion did so because they believe that the program serves as an important safety net for vulnerable members of society.[407]

Other stakeholders who have spoken out in support of Medicaid expansion include health care providers and business owners. Health care providers in Red States are facing a health reform bait–and–switch with the loss of DSH funding and the remaining cost of treating uninsured patients who otherwise could be covered by Medicaid expansion.[408] Business owners may face increased costs from the pressure to provide health insurance to low–income employees who would otherwise be Medicaid–eligible, and from higher premiums for currently insured employees as health care providers attempt to shift the costs of uncompensated care.[409] These groups, while traditionally more aligned with conservative agendas, could represent a compelling constituency to push Red State leaders toward Medicaid expansion, given this economic impact.

The Arkansas plan represents the fourth and fifth elements of the Red State Narrative. The fourth is that Red State leaders need a way to save political face. The fifth is that the plan must retain a significant nod to the private market. Having gone to the mat, challenging the constitutionality of Medicaid expansion all the way to the nation's highest court and vowing repeatedly to

402 Domrzalski, *supra* note 260 (quoting Governor Martinez).

403 *See supra* notes 19–22 (referring to Roberts's and Ginsburg's opinions).

404 *See* Bositis, *supra* note 235, at 5 tbl.2 (reporting findings that 85.3% of African Americans surveyed supported Medicaid expansion, compared to 53.3% non–Hispanic whites).

405 *See id.* at 10–21 (discussing respondents' reactions to five arguments and/or factual reasons to support Medicaid expansion).

406 *Id.* at 12–13 & tbl.2 (regarding argument that Medicaid expansion would create new jobs, economic activity, and tax revenue, which 27% of opponents found persuasive).

407 *Id.* at 20–21 & tbl.2 (regarding safety net argument, convincing to 57% of respondents).

408 *See supra* notes 224–27 and accompanying text (describing DSH cuts, as related to Medicaid opt out).

409 *See supra* notes 228–29 (discussing employer impact of Medicaid opt out).

decline federal invitations to support health reform, these lawmakers now need a way to alter their positions without alienating supporters. Even if convinced by the economic models or the political pressure of significant constituencies, they need a way to retain some sense of Tea Party dignity. For Arkansas's Republican legislature and, to a lesser degree, Florida's Governor Scott, the face–saving maneuver was the suggestion that they fought for—and won—meaningful concessions from the federal government.[410] They wanted to convey an image of negotiated federalism.[411]

In Arkansas, that image was cultivated by portraying the premium support privatized approach to Medicaid expansion as a radically new design, a "game changer,"[412] even though the option to enroll Medicaid beneficiaries in private, individual health insurance plans has been available to states since the beginning of the program.[413] Historically, however, the individual insurance market has not functioned adequately to offer affordable products that would meet Medicaid requirements. The hope is that the newly created health insurance exchanges will make that possible. But significant questions remain about how the Arkansas plan will be implemented.

Nevertheless, the concept has attracted considerable attention from other Red States' leaders, who recognize the financial benefits of Medicaid expansion but do not want to compromise their Tea Party bona fides.[414] The plan allows Republican lawmakers in the state, first, to tout the "victory" they scored in getting federal authorities to agree to the privatized approach and, second, to stay true to their preference for market–based solutions to social problems.

Although less radical than the Arkansas plan, Governor Scott of Florida employed a similar strategy, publicly announcing that the state had "won" two Medicaid waivers from the federal government just before announcing his

410 *See* Using Medicaid Dollars, *supra* note 284 ("[T]he main benefit [of the Arkansas plan] would be political in that it could engage Republicans in the whole health reform effort, make it easier to carry out the law and reduce the appetite among Congressional Republicans to gut the law.").

411 *See supra* note 12 (discussing various scholars' depictions of federalism as a negotiated process between federal and state authorities).

412 *See supra* note 269 and accompanying text; Rosenbaum & Sommers, *The Great New Experiment*, *supra* note 15, at 8.

413 *See supra* note 126 and accompanying text (discussing Medicaid program premium support provisions).

414 *See* Rosenbaum & Sommers, *The Great New Experiment*, *supra* note 15, at 7 ("[O]ther states, including Ohio, appear to be negotiating with the federal government over replacing the standard Medicaid approach with premium assistance."); Rovner, *supra* note 270 ("[T]he Arkansas plan] has caught the attention of several other Republican–run states that had been holding out on the Medicaid expansion, including Ohio, Florida and even Texas."); Somashekhar, *supra* note 283 ("[Federal] HHS officials have indicated other states might be permitted to use a similar strategy [to Arkansas's]."); *see* Johnson, *supra* note 14 ("Republican governors and lawmakers in other states such as Michigan, Pennsylvania and Iowa are asking the CMS to allow alternative models for expanding coverage.").

support for Medicaid expansion.[415] House Republicans in Florida, however, had different ideas. Instead, they proposed a fully state–funded, much more limited, voucher program, available to uninsured individuals who were willing and able to make a modest monthly contribution and maintain certain work–hour requirements. The proposal would cover just over half of the Medicaid expansion population, the remainder of which would be left to fend for themselves.

The Michigan legislation signed after a special summer session and the proposal still under consideration in Florida are examples of the fifth element of the Red State Narrative—retaining market–based models of delivery. The Michigan law retains strong private market and individual responsibility components, consistent with preferences of those opposing Obamacare. If the federal government approves Michigan's waivers, low–income, non–disabled adults would receive Medicaid but still would be treated differently than the traditional "deserving poor." They would be required to pay annual copayments, as a percentage of their income, and would have to manage a portion of their own health care costs through health savings accounts. Moreover, the expansion population would be discouraged from long–term dependence on government assistance, with increased financial obligations after a certain time limit.

Florida's proposed version, a fully state–funded and administered program, takes those approaches to the extreme. Under the CARE plan, Medicaid beneficiaries would face substantial cost–sharing obligations and would be fully exposed to the private insurance market. Florida's approach does little to advance the Red State Narrative of bringing recalcitrant states toward acceptance of Medicaid expansion. Rather, it is premised on all of the familiar objections to expansion, including concerns about federal authorities reneging on the funding promise, reluctance to expand a dysfunctional public welfare program, desire to limit federal involvement in state affairs, and philosophical objections to programs that increase individuals' dependency on government assistance. The current impasse in the Florida legislature likely cannot be overcome unless other elements of the Red State Narrative are invoked.

Conclusion

As part of Congress's goal of near universal health insurance coverage, the ACA granted states extraordinarily generous federal financial support to extend their existing Medicaid programs to additional low–income, uninsured individuals. Congress declared everyone below 138% FPL eligible for government health insurance and promised to pay the lion's share of the costs for those new beneficiaries. It was a very good deal for states.

Nevertheless, twenty–six states challenged the constitutionality of the ACA's Medicaid expansion as unduly "coercive." Their claim was that the amendment made their existing federal Medicaid funding contingent on accepting the new

415 *See supra* notes 349–52 and accompanying text (quoting Governor Scott's press release and other sources).

funding under the ACA. Against all odds, the Supreme Court accepted this argument and held that the Medicaid expansion could stand only if states had a choice whether to accept it or not. States that opted in would receive the generous federal funding and would be required to cover the new group. States that opted out could continue to operate their Medicaid programs and receive federal funding under the pre–ACA terms.

One year after the Court's decision, a bare majority of states have agreed to expand Medicaid while the rest have either affirmatively refused or delayed deciding whether to expand. This Article focuses on the political landscape in those latter states electing the so–called Red State Option. It draws lessons from a significant group of Republican–controlled states that broke ranks and joined the former group of opt–in states.

In financial terms, Medicaid expansion seems like the obvious choice. States can cover a group of historically uninsured adults and children at little to no cost to themselves. Doing so further relieves their health care providers and employers of the cost of treating or insuring those individuals. Medicaid expansion can also contribute to job growth and increased tax revenue resulting from that economic activity. Moreover, Medicaid expansion has broad popular support, especially among certain minority populations likely to benefit from the program. Despite these facts, some states remain recalcitrant, hewing the Tea Party rhetoric that is anti–"Obamacare," anti–Big Government, and anti–public welfare.

This Article offers those states a way forward—a Red State Narrative that allows them to take advantage of the generous federal funding without losing political face. Case studies of other Red States inform the narrative, suggesting certain essential dynamics. First, states must adjust their understanding of the Supreme Court's opinion and recognize that the ACA's amendments to the Medicaid program are not, after all, constitutionally significant. Second, states must acknowledge the nearly irrefutable economic analyses demonstrating the net benefit of Medicaid expansion. Third, a politically compelling constituency within opt–out or hold–out states may have to push for expansion. Fourth, Red State lawmakers must be able to suggest at least the appearance of a negotiated settlement, including a significant concession from the federal government, before they agree to expansion. Fifth and finally, Red States will prefer for their particular version of Medicaid expansion to operate largely within the private health insurance market, consistent with conservative health reform strategies.

As state legislatures reconvene for the 2014 session, they will have the opportunity to reconsider their current Medicaid expansion elections. Opt–in states will be able to evaluate whether the financial and other incentives are paying off. Opt–out states will have a year of data on the budgetary and political impact of declining federal funding. The Article anticipates that the elements of the Red State Narrative will persuade at least some of those states to provide government assistance to a deserving group of low–income, uninsured individuals within their borders.