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Situational Irony? How Implementing a Medicaid Block Grant Will Exacerbate Everything It Purports to Fix

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Situational Irony?
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For decades conservative leaders within the federal government have sought to block grant entitlement programs, the foremost among them being Medicaid.[1] As history tends to repeat itself, the election of a Republican President and Republican

1. *See* JOHN HOLAHAN & MATTHEW BUETTGENS, URB. INST., BLOCK GRANTS AND PER CAPITA CAPS THE PROBLEM OF FUNDING DISPARITIES AMONG STATES 1 (2016), http://www.urban.org/sites/default/files/publication/83921/2000912-Block-Grants-and-Per-Capita-Caps-the-Problem-of-Funding-Disparities-among-States.pdf [hereinafter BLOCK GRANTS AND PER CAPITA CAPS] ("Over the past 25 years, various Congressional leaders have called for Medicaid financing to be reformed with either block grants or per capita caps."); *see also* A BETTER WAY, A BETTER WAY: OUR VISION FOR A CONFIDENT AMERICA 25 (2016), https://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf [hereinafter A BETTER WAY]; Jeanne M. Lambrew, *Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals*, 83 MILBANK Q. 41, 45 (2005) ("President Reagan proposed changing Medicaid into a block grant program in 1981, Speaker of the House of Representatives Newt Gingrich proposed it in 1995, and President Bush proposed it in 2003. President George H.W. Bush also considered the idea but withdrew it before it was drawn up as a specific program."); *see generally* Michael S. Sparer, *Medicaid at 50: Remarkable Growth Fueled by Unexpected Politics*, 34 HEALTH AFF. 1084-89 (2015) (providing a comprehensive history of the Medicaid program).

majorities in both the Senate and House of Representatives have led to renewed calls to block grant Medicaid.[2] Block grant proponents advocate the necessity of the change by highlighting the virtues of block grants; specifically, that block grant implementation will provide states flexibility in their Medicaid program[3] while simultaneously encouraging fiscal prudence in this program that is often accused of significant excesses.[4] Block grant proponents argue that restored state flexibility and enhanced fiscal prudence will best serve the interests of Medicaid beneficiaries.[5]

The current structure of Medicaid guarantees coverage to qualified low-income individuals and guarantees federal matching payments to states without any preset enrollment limits.[6] The

2. *See, e.g.*, Joseph R. Antos & James C. Capretta, *The Graham-Cassidy Plan: Sweeping Changes in a Compressed Time Frame*, HEALTH AFFS.: HEALTH AFFS. BLOG (Sept. 22, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170922.062134/full/; Aaron E. Carroll, *How Would Republican Plans for Medicaid Block Grants Actually Work?*, N.Y. TIMES: THE UPSHOT (Feb. 6, 2017), https://www.nytimes.com/2017/02/06/upshot/how-would-republican-plans-for-medicaid-block-grants-actually-work.html; Ryan LaRochelle, *The GOP Plan to Fund Medicaid Through Block Grants Will Probably Weaken It*, WASH. POST: MONKEY CAGE (Jan. 18, 2017), https://www.washingtonpost.com/news/monkey-cage/wp/2017/01/18/republicans-want-to-fund-medicaid-through-block-grants-thats-a-problem/?utm_term=.f33c2a0f42ed; Shefali Luthra, *Block Grants Are the Heart of GOP's Medicaid Plans. Here's How They Work*, PBS: NEWS HOUR (Jan. 25, 2017, 10:16 AM), http://www.pbs.org/newshour/rundown/block-grants-republican-medicaid; Vann R. Newkirk II, *Republicans' New Plan to Gut Public Insurance*, ATLANTIC: POLITICS (Feb. 18, 2017), https://www.theatlantic.com/politics/archive/2017/02/house-gop-obamacare-plan-block-grants/517104/.

3. *See* A BETTER WAY, *supra* note 1, at 25 ("All states should have more flexibility to adapt their Medicaid programs, to better design benefit packages in a way that better meets the needs of their state populations, promotes personal responsibility and healthy behaviors, and encourages a more holistic approach to care."); Lambrew, *supra* note 1, at 42 ("Advocates of block grants make two claims. The first is the idea of federalism, or giving control of the grants to the states.").

4. *See* A BETTER WAY, *supra* note 1, at 23 ("Many state Medicaid programs suffer from significant waste, fraud, and abuse, due to failures in state and federal oversight."); Lambrew, *supra* note 1, at 43 ("A second argument for block grants is that they would eliminate the 'uncontrollable' aspects of entitlement programs. Congress sets in advance the maximum amount of federal block grant spending, which offers both predictability and a relatively easy way to adjust the program's spending to meet broader budget goals." (citation omitted)).

5. *See* A BETTER WAY, *supra* note 1, at 28 ("This approach allows states to design programs to best meet the unique needs of their citizens.").

6. *See* ROBIN RUDOWITZ, KAISER FAMILY FOUND., MEDICAID FINANCING: THE BASICS 2 (2016), http://files.kff.org/attachment/Issue-Brief-Medicaid-Financing-The-Basics [hereinafter MEDICAID FINANCING: THE BASICS]; *see also* CTR. ON BUDGET & POL'Y PRIORITIES, INTRODUCTION TO MEDICAID 2 (2016), http://www.cbpp.org/sites/default/files/atoms/files/policybasics-medicaid_0.pdf [hereinafter INTRODUCTION TO MEDICAID] ("Medicaid is an

receipt of federal funding is conditional upon the states meeting a broad range of federal requirements.[7] Generally, these requirements consist of states providing specific services to qualified populations (almost unanimously the poor) without limitations.[8] The federal matching also covers other "optional" populations; consequently, this allows states to qualify different population groups, such as the Affordable Care Act (ACA) expansion group, as Medicaid beneficiaries.[9] The federal share of matching payments

'entitlement' program, which means that anyone who meets eligibility rules has a right to enroll in Medicaid coverage. It also means that states have guaranteed federal financial support for part of the cost of their Medicaid programs."); KAISER COMM'N ON MEDICAID & UNINSURED, KAISER FAMILY FOUND., IMPLICATIONS OF A FEDERAL BLOCK GRANT FOR MEDICAID 1 (2011), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8173.pdf [hereinafter IMPLICATIONS OF A FEDERAL BLOCK GRANT FOR MEDICAID] ("Medicaid covers low-income individuals who meet categorical and income standards including children and parents, individuals with diverse physical and mental conditions and disabilities, and seniors.").

7. *See* MEDICAID FINANCING: THE BASICS, *supra* note 6, at 2; *see also* INTRODUCTION TO MEDICAID, *supra* note 6, at 2. The Center on Budget and Policy Priorities indicates that the mandatory populations a state must cover, to qualify for federal funding, include:

- children through age 18 in families with income below 138 percent of the federal poverty line ($25,975 for a family of three in 2013);
- pregnant women with income below 138 percent of the poverty line;
- parents whose income is within the state's eligibility limit for cash assistance that was in place prior to welfare reform; and
- most seniors and persons with disabilities who receive cash assistance through the Supplemental Security Income (SSI) program.

Id.

8. *See* MEDICAID FINANCING: THE BASICS, *supra* note 6, at 2; *see also* SARA ROSENBAUM ET AL., COMMONWEALTH FUND, WHAT WOULD BLOCK GRANTS OR LIMITS ON PER CAPITA SPENDING MEAN FOR MEDICAID? 1 (2016), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2016/nov/1913_rosenbaum_medicaid_block_grants.pdf ("Medicaid has transformed from a niche program to become a linchpin of the U.S. health care system. It is today the largest single insurer, serving nearly 73 million low-income and medically vulnerable individuals, many of whom would go without needed care or face severe financial hardship without this coverage.").

9. *See* MEDICAID FINANCING: THE BASICS, *supra* note 6, at 2; *see also* INTRODUCTION TO MEDICAID, *supra* note 6, at 2. The Center on Budget and Policy Priorities outlined Medicaid policy in regard to optional populations, explaining:

> States may also receive federal Medicaid funds to cover "optional" populations, including: pregnant women, children, and parents with income above "mandatory" coverage income limits; seniors and persons with disabilities with income below the poverty line; "medically needy" people (those whose income exceeds the state's regular Medicaid eligibility limit but who have high medical expenses, such as for nursing home care, that reduce their disposable income below the eligibility limit); and newly under health reform, near-poor non-disabled adults without children.

varies by state—depending on the specific state and the identified population group.[10]

Specifically, the federal government provides a matched share of payments to states for the traditional Medicaid population.[11] The matching percentage is determined statutorily, based on the state's per capita income, which varied from a floor of 50% to a maximum of 74% in 2017.[12] For specific subsets of the population, the federal government might follow another formula. As an example, for the Medicaid expansion populations under the ACA, the federal government paid 100% of the costs to include the expansion population through 2016, with its share being gradually reduced to 90% by 2020.[13]

Block granting Medicaid would transform its structure from a federal open-ended, matched funding entitlement program into a program where states receive a predetermined, fixed amount of funds, based only on the historical expenditures of the specific state.[14] The rationale behind this change is that the federal requirements will be disregarded in favor of state flexibility (with a more favorable state "formula").[15] However, switching Medicaid to

Id. The fact that Medicaid covers vulnerable populations has saved the program from previous attempts to block grant its funding. *See* Lambrew, *supra* note 1, at 42.

10. *See* MEDICAID FINANCING: THE BASICS, *supra* note 6, at 2 ("The federal share of Medicaid is determined by a formula set in statute that is based on a state's per capita income. The formula is designed so that the federal government pays a larger share of program costs in poorer states.").

11. *See id.*

12. MISS. DIV. OF MEDICAID, MISSISSIPPI MEDICAID: AN OVERVIEW AND PROGRAM BASICS 1 (2017), https://medicaid.ms.gov/wp-content/uploads/2017/01/2017-Medicaid-Fact-Sheet.pdf; *see also* MEDICAID FINANCING: THE BASICS, *supra* note 6, at 2 ("The federal share (FMAP) varies by state from a floor of 50% to a high of 74% in 2017, and states may receive higher FMAPs for certain services or populations.").

13. *See* MEDICAID FINANCING: THE BASICS, *supra* note 6, at 2; *see also* INTRODUCTION TO MEDICAID, *supra* note 6, at 2–3.

14. *See* EDWIN PARK, CTR. ON BUDGET & POL'Y PRIORITIES, MEDICAID BLOCK GRANT WOULD SLASH FEDERAL FUNDING, SHIFT COSTS TO STATES, AND LEAVE MILLIONS MORE UNINSURED 1 (2016), http://www.cbpp.org/sites/default/files/atoms/files/11-30-16health_0.pdf [hereinafter MEDICAID BLOCK GRANT WOULD SLASH FEDERAL FUNDING]; *see also* Lambrew, *supra* note 1, at 42 ("Medicaid guarantees that certain low-income and disabled persons receive a set of comprehensive health benefits defined by federal and state law. The funding for such services rises and falls according to need. Under a block grant plan, however, the situation would be reversed.").

15. *See* ROBERT JAY DILGER & EUGENE BOYD, CONG. RESEARCH SERV., BLOCK GRANTS: PERSPECTIVES AND CONTROVERSIES 3 (2014) [hereinafter BLOCK GRANTS: PERSPECTIVES AND

a state block grant, with the accompanying loss of the federal entitlement, would likely cause other fundamental changes, including a lack of guaranteed coverage to otherwise qualified individuals[16] and capped federal funding (not based on enrollment or program needs)[17] set only to fixed, pre-set growth factors such as the consumer price index.[18] Furthermore, all Medicaid block grant proposals employ a grant growth rate set below the medical inflation rate projected by the Congressional Budget Office or the Centers for Medicare & Medicaid Services for the Medicaid program—thereby creating the intended federal savings over time.[19] This block granting structure, however, would impede Medicaid's function of providing a healthcare safety net for the poor.[20] Specifically, the touted methods aimed at promoting flexibility and financial prudence would likely result in cuts to beneficiary enrollment and benefits.[21]

CONTROVERSIES]. Dilger and Boyd describe the nature of the "formula" for a block grant with the following:

> Federal administrators have a low degree of discretion over who receives block grants (after setting aside funding for administration and other specified activities, the remaining funds are typically allocated automatically to recipients by a formula or formulas specified in legislation); recipients have some discretion concerning aided activities (typically, funds can be used for a specified range of activities within a single functional area); and there is a moderate degree of federal administrative conditions attached to the grant, typically involving more than periodic reporting criteria and the application of standard government accounting procedures, but with fewer conditions attached to the grant than project categorical grants.

Id.

16. *See* BLOCK GRANTS AND PER CAPITA CAPS, *supra* note 1, at 2 ("Block grants would end Medicaid's open-ended matching structure whereby states receive federal matching payments based on their expenditures.").

17. *See* MEDICAID BLOCK GRANT WOULD SLASH FEDERAL FUNDING, *supra* note 14, at 3 ("This could include using waiting lists or capping enrollment; under current law, all eligible individuals who apply for Medicaid must be allowed to enroll.").

18. *See* BLOCK GRANTS AND PER CAPITA CAPS, *supra* note 1, at 3.

19. *See id.*

20. *See* KAISER FAMILY FOUND., MEDICAID IN THE UNITED STATES 1 (2017), http://files.kff.org/attachment/fact-sheet-medicaid-state-US [hereinafter MEDICAID IN THE UNITED STATES].

21. *See* MEDICAID BLOCK GRANT WOULD SLASH FEDERAL FUNDING, *supra* note 14, at 3 ("To compensate for . . . funding cuts a block grant would institute, states would either have to contribute much more of their own funding or, as is far more likely, use the greater flexibility the block grant would give them to make draconian cuts to eligibility, benefits, and provider payments.").

While other Medicaid block grant literature has been limited primarily to the projected consequences of instituting a Medicaid block grant,[22] this Note will attempt to fill a gap in the literature by evaluating the legal and policy mechanisms behind the block grant proponent's claims of increased state flexibility and enhanced fiscal prudence. Finding the legal and policy mechanisms endorsed by Medicaid block granting proponents incorrect, this Note will argue that both conservative and liberal Medicaid objectives can be reached—achieving state flexibility with fiscal prudence while not reducing the accumulative Medicaid population or specific coverage benefits—by formulating Medicaid law around the policy that early treatments of diseases provide significant savings without requiring cuts to coverage. Ironically, the actual objectives sought through block granting Medicaid are best achieved by completely abandoning the block grant proposal in lieu of laws based on this policy that provides earlier treatments and expansive coverage to more people.

This Note will proceed as follows: Part I will explore the state flexibility rationale for Medicaid block granting—including increased state Medicaid freedom, effectiveness, and innovation—and suggest that block granting would actually frustrate these objectives. Part II examines the other purported aim of Medicaid block grants, the promotion of fiscal prudence, and argues that block granting would ultimately undermine state economies. The states, because of legal impediments, would not be able to compensate for fiscal shortfalls created by a block grant. Part II will also introduce the idea of implementing policies that increase coverage to beneficiaries by arguing that expanded coverage creates immediate economic benefits, with such early treatment also providing significant downstream savings to the government. These savings will promote what block granting proponents seek: long-term planning, streamlining of duplicative programs, and limits on uncontrollable costs—making the choice to expand Medicaid coverage the superior option. Part III concludes by

22. Reasons for this omission in literature appear to be based on the difficulties of analyzing a non-existent policy. *See, e.g.*, Lambrew, *supra* note 1, at 42 ("Beyond simulations, the idea of converting Medicaid to a block grant has not been well studied. Indeed, it is difficult to assess the implications of a policy that does not now exist and for which there are few analogues.").

suggesting that despite Medicaid's vulnerability to calls for moving to a block granting approach, there is reason to be optimistic for the future of Medicaid.

I. STATE FLEXIBILITY

Highlighting the historical roots of federalism as justification, block grant proponents seek to provide states wide discretion in their Medicaid block grant implementation.[23] This is a significant change as the benefits of the Medicaid program have, over time, become entrenched in society and have become "programmatic rights"—rights that are administered via a joint government program as the products of congressional enactment and judicial interpretation.[24] Further illustrating the societal entrenchment of programmatic rights, the Supreme Court has suggested, in dicta, that welfare entitlements might be property rights.[25] Consequently, switching Medicaid from a federal entitlement into a state program will lead to an argument on how increased state flexibility will impact Medicaid beneficiaries' programmatic rights.[26]

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23. *See* Stephen D. Sugarman, *Welfare Reform and the Cooperative Federalism of America's Public Income Transfer Programs*, 14 YALE L. & POL'Y REV. 123, 140 (1996) ("Federalism is also often praised for providing variety in government, thereby giving people with different tastes reason to live in one locale or another—although this idea is traditionally more frequently applied to local variation, not so much to state-to-state variation."); *see also* Lambrew, *supra* note 1, at 44 (describing the differences among states in their desire for control over their Medicaid program, with some wishing for more control, while others seek to relinquish control to the federal government).

24. *See* R. Shep Melnick, *Federalism and the New Rights*, 14 YALE L. & POL'Y REV. 327, 327 (1996) ("Unlike the rights of free speech, religion, property, and privacy, which set limits on the power of government officials, programmatic rights require extensive public programs rather than private autonomy, a welfare state rather than limited government.").

25. *See* Goldberg v. Kelly, 397 U.S. 254, 262 n.8 (1970) ("It may be realistic today to regard welfare entitlements as more like 'property' than a 'gratuity.' Much of the existing wealth in this country takes the form of rights that do not fall within traditional common-law concepts of property.").

26. *See* Melnick, *supra* note 24, at 326. Melnick adds clarity and caution to the idea of federalism being used to promote policy change with the following statement:

> In short, in the US debates about federalism are seldom merely matters of efficiency, management, or finding the most convenient means for achieving agreed-upon ends. These debates are often proxies for broader arguments about the proper role of government. This should make us ponder what the current trend toward devolution of authority means for the way we define and enforce individual rights.

Id.

The following sections will argue that the specific types of Medicaid flexibility that proponents claim states will experience with block grants—(1) expanding state freedom, (2) incentivizing program effectiveness, and (3) fostering state innovation—will each actually limit state flexibility and obstruct beneficiaries' programmatic rights as they are currently enjoyed.

A. State Freedom

A repeated argument against the current entitlement structure of Medicaid is that it constrains state policy-making.[27] Currently, states are bound to federal requirements such as mandating essential services and covering specific population groups.[28] Additionally, the statutory requirements of Medicaid provide that all who meet specific income criteria qualify for coverage.[29] The statutory requirements also enable beneficiaries to defend in federal court their "enforceable rights" against state action that could unlawfully harm their interests.[30]

While acknowledged as a "cooperative" program between states and the federal government, proponents of Medicaid block grants argue the actual result is a federal program administered by the state that is accompanied with strict requirements in exchange for a set amount of resources.[31] Proponents also contend that this

27. *See* A BETTER WAY, *supra* note 1, at 12. The current Republican proposal has outlined:

> States have been in the business of regulating health insurance for decades. They should be empowered to make the right tradeoffs between consumer protections and individual choice, not regulators in Washington. The federal role should be minimal and set a few broadly shared goals, while state governments determine how best to implement those goals in their own markets.

Id.; *see also* Lambrew, *supra* note 1, at 44 ("Medicaid has been the target of block grant proponents in part because of the inherent tension in the federal-state partnership.").

28. *See* INTRODUCTION TO MEDICAID, *supra* note 6, at 2 (discussing the mandatory populations states must cover to receive Medicaid funding).

29. See 42 U.S.C § 1396a(a)(10) (2012), *amended by* Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, Pub. L. No. 115-271, 132 Stat. 3894, 3902 (2018).

30. *See* Jerry L. Mashaw & Dylan S. Calsyn, *Block Grants, Entitlements, and Federalism: A Conceptual Map of Contested Terrain*, 14 YALE L. & POL'Y REV. 297, 301 (1996); *see also* SARA ROSENBAUM, COMMONWEALTH FUND, MEDICAID AND THE ROLE OF THE COURTS 4–5 (2018), https://www.commonwealthfund.org/sites/default/files/2018-06/Rosenbaum_Medicaid_and_the_Courts_v2.pdf [hereinafter MEDICAID AND THE ROLE OF THE COURTS].

31. *See* Mashaw, *supra* note 30, at 297–99, 299 n.6.

broad federal program inhibits the states from responding to specific, local needs.[32] Here, the Medicaid block grant is advertised as an effective method to get the decision-making power "closer to the people," which—in theory—will be more "visible" to a state's populace; thus, the Medicaid program will be more responsive to the needs of Medicaid beneficiaries.[33]

State freedom in both the policy-making and administration of a Medicaid block grant is likely more illusory than genuine.[34] As an illustration of possible limitations on state policy-making and administration, the Community Development Block Grant,[35] though commonly identified as a success story,[36] also demonstrates the multitude of conditions and sub-conditions that often accompany the receipt of a block grant, limiting the policy-making power of the state.[37] These conditions and sub-conditions are often

32. *See* A BETTER WAY, *supra* note 1, at 25 ("Regrettably, in recent years the federal-state balance has shifted since the passage of the Affordable Care Act, redefining federalism—where programs that should be administered locally are being overseen by political appointees and career bureaucrats in Washington issuing new rules and regulations.").

33. *See id.* The interpretation of devolution further includes the following idea:

> [G]overnors and state legislatures are closer to patients in their states and know better than Washington bureaucrats where there are unmet needs and opportunities to cut down on waste, fraud, and abuse. All states should have more flexibility to adapt their Medicaid programs, to better design benefit packages in a way that better meets the needs of their state populations, promotes personal responsibility and healthy behaviors, and encourages a more holistic approach to care.

Id.

34. *See* Mashaw & Calsyn, *supra* note 30, at 306 (explaining that even if block grants met all their proposed goals, block grants would still "have a problematic relationship to devolution of political discretion from the central government to the states").

35. *See* 42 U.S.C. § 5301 (2012).

36. *See* Mashaw & Calsyn, *supra* note 30, at 306 n.27.

37. *See* 42 U.S.C. §§ 5301–5321 (2012); Mashaw & Calsyn, *supra* note 30, at 306. Mashaw and Calsyn specifically state:

> In many ways, state discretion has been limited even within block grant funding formula. Techniques which have been used include the auditing of the grantee's expenditures, requiring grantees to file plans for the use of the money, creation of "discretionary funds" for federal administrators to target development of a hybrid block-categorical grant which targets certain populations, or mandating public hearings on the use of the funds. Additional ways of limiting discretion include "pass through" requirements which specify that the grantee distribute the funds, or a portion of the funds, in certain prescribed proportions and "set asides" that simply prioritize within a block grant.

Id. at 306 n.27.

described as a block grant's "formula."[38] To illustrate, this specific block grant's formula requires that the grantees institute a citizen participation plan,[39] submit to an annual review and audit by the Secretary of Program Implementation,[40] and have ready all necessary items for receipt by the Government Accountability Office for auditing purposes.[41] The block grant also specifically identifies the activities to which grant funds may be allocated,[42] the requirements on fund allocations,[43] and the standards required of laborers and their wages.[44] This block grant also requires guarantees of commitments from the state to assure grant resources are used for the acquisition of property;[45] additionally, this block grant has remedial procedures for states who do not comply with the block grant's requirements.[46] If this supposedly 'successful' block grant is any indication of Medicaid's future, states may not

38. *See* BLOCK GRANTS: PERSPECTIVES AND CONTROVERSIES, *supra* note 15, at 3 ("Federal administrators have a low degree of discretion over who receives block grants (after setting aside funding for administration and other specified activities, the remaining funds are typically allocated automatically to recipients by a formula or formulas specified in legislation) . . . .").

39. *See* 42 U.S.C § 5304(a)(3) (2012). This section of the Community Development statute indicates that a grant will only be made when the citizen participation plan provides and encourages citizen participation (subsection A), timely access to local meetings (subsection B), information and records relating to proposed use of funds (subsection B), technical assistance to groups of low and moderate income who request such assistance (subsection C), public hearings (subsection D), the providing of written answers to complains and grievances within fifteen working days where possible (subsection E), and providing for the needs of non-English speaking citizens (subsection F), etc. *Id.*

40. *See id.* § 5304(e).

41. *See id.* § 5304(f). Recipients are required to provide:

> Insofar as they relate to funds provided under this chapter, the financial transactions of recipients of such funds may be audited by the Government Accountability Office under such rules and regulations as may be prescribed by the Comptroller General of the United States. The representatives of the Government Accountability Office shall have access to all books, accounts, records, reports, files, and other papers, things, or property belonging to or in use by such recipients pertaining to such financial transactions and necessary to facilitate the audit.

Id.

42. *See id.* § 5305.

43. *See id.* § 5306.

44. *See id.* § 5310.

45. *See id.* § 5308.

46. *See id.* § 5311.

only expect similar confining conditions, but also restrictions on the freedom of states to craft their own policies.[47]

Aside from possible policy limitations, the intrinsic nature of the block grant funding will impede state freedom with the constraints of medical inflation outpacing annual block grant growth; consequently, states will almost certainly have to make drastic cuts to beneficiary benefits and populations.[48] As previously discussed, the nature of a block grant is designed to provide less federal funding over the course of time.[49] This is done by finding a state's spending in a particular year, capping that amount for an extended period of time, and only adjusting the capped figure over the course of time for general inflation.[50] This approach is problematic as the specific inflation rate for healthcare has, at times, outpaced general inflation;[51] additionally, the standard increase for only general inflation simultaneously leaves no room for changing program needs due to recessions, epidemics, disasters, etc.[52] As the

47. *See* Nicholas Bagley, *Federalism and the End of Obamacare*, 127 YALE L.J. F. 1, 24 (2017) ("Proposals to transform Medicaid into a block-grant program may trade on the rhetoric of states' rights, but they have the perverse effect of inhibiting state power.").

48. *See* MEDICAID BLOCK GRANT WOULD SLASH FEDERAL FUNDING, *supra* note 14, at 1. The Center on Budget and Policy Priorities has predicted the following consequences of a Medicaid block grant:

> A Medicaid block grant would institute deeps cuts to federal funding for state Medicaid programs and threaten benefits for tens of millions of low-income families, senior citizens, and people with disabilities. To compensate for these severe funding cuts, states would likely have no choice but to institute draconian cuts to eligibility, benefits, and provider payments.

Id.

49. *See supra* notes 6–13 and accompanying text.

50. *See* MEDICAID BLOCK GRANT WOULD SLASH FEDERAL FUNDING, *supra* note 14, at 2. The Center on Budget and Policy Priorities has suggested that this structure of the block grant is certain:

> Because a Medicaid block grant is explicitly intended to produce significant federal budgetary savings, block grants are designed in ways that give states considerably less federal funding each year than they would receive under the current financing system. That is typically accomplished by basing a state's initial block grant amount on its current or historical spending and then increasing it annually at a considerable slower rate—such as general inflation—than the currently projected annual growth in federal Medicaid spending. The resulting federal funding cuts would thus grow steadily larger each year.

Id.

51. *See* Bloomberg, *Healthcare Prices to Outpace Inflation for the First Time Since 2010*, FORTUNE (Feb. 15, 2018), http://fortune.com/2018/02/15/healthcare-prices/.

52. *See* IMPLICATIONS OF A FEDERAL BLOCK GRANT FOR MEDICAID, *supra* note 6, at 1–2.

Temporary Assistance for Needy Families (TANF) block grant analogously illustrates: from 1996 to 2016, the value of the block grant, capped and not adjusted for inflation, diminished in value by nearly a third.[53] Despite the federal government's creation of a TANF emergency fund during the Great Recession to assist cash-strapped states, at least forty-six states responded to the recession by instituting cuts in social services and cash assistance.[54] Such cuts are currently unrestored.[55]

Most importantly, Medicaid already promotes state freedom — a freedom unfettered by cuts to enrollment or benefits.[56] Current Medicaid policies already allow states significant freedom to expand enrollment, such as covering additional populations like the ACA Medicaid-expansion group, or to provide additional benefits such as dental and vision care.[57] Consequently, nearly 60% of Medicaid spending consists of optional spending not required by federal law.[58] States are also free to set reimbursement rates

53. *See* ELIZABETH LOWER-BASCH, CLASP, TANF BLOCK GRANT 4 (2016), http://www.clasp.org/resources-and-publications/publication-1/TANF-101-Block-Grant.pdf [hereinafter TANF BLOCK GRANT] ("Under the 1996 law, the basic TANF block grant was fixed at $16.57 billion a year. This figure has not been increased to reflect inflation since TANF was first created. This, the value of the block grant has been eroded by 33 percent.").

54. *Id.*

55. *See id.* ("During the Great Recession, increased demands for assistance and expanded federal support were counterbalanced by strained state budgets . . . . Total spending on child care assistance is at a 12-year low.").

56. *See* HANNAH KATCH, CTR. ON BUDGET & POL'Y PRIORITIES, STATES ARE USING FLEXIBILITY TO CREATE SUCCESSFUL, INNOVATIVE MEDICAID PROGRAMS 1 (2016), http://www.cbpp.org/sites/default/files/atoms/files/6-13-16health.pdf. The Center on Budget and Policy Priorities suggests that Medicaid is sufficiently flexible, stating:

> State Medicaid programs across the country are tailoring services and models of care to local needs in ways that streamline health care delivery and improve health. These innovative models demonstrate that current Medicaid rules allow states significant flexibility, and disprove claims by proponents of block-granting Medicaid or imposing a per capita cap, as the House Republican budget plan would do, that current Medicaid rules inhibit state reforms.

Id.

57. *See* MEDICAID AND THE ROLE OF THE COURTS, *supra* note 30, at 2 (discussing the Supreme Court of the United States' role in making the ACA's Medicaid expansion optional); JANUARY ANGELES, CTR. ON BUDGET & POL'Y PRIORITIES, RYAN MEDICAID BLOCK GRANT WOULD CAUSE SEVERE REDUCTIONS IN HEALTH CARE AND LONG-TERM CARE FOR SENIORS, PEOPLE WITH DISABILITIES, AND CHILDREN 3 (2011), http://www.cbpp.org/sites/default/files/atoms/files/5-3-11health.pdf [hereinafter RYAN MEDICAID BLOCK GRANT WOULD CAUSE SEVERE REDUCTIONS IN HEALTH CARE].

58. *See* RYAN MEDICAID BLOCK GRANT WOULD CAUSE SEVERE REDUCTIONS IN HEALTH CARE, *supra* note 57, at 3–4 (citation omitted).

for providers and to implement cost-saving, managed-care plans for Medicaid beneficiaries.[59] These examples, among others, suggest that the expanded freedom touted by Medicaid block grant proponents is likely rhetorical. Any liberating effect created by a block grant will be offset by unacceptable reductions both in state autonomy and in benefits received by the beneficiaries themselves.[60]

B. Medicaid Effectiveness

Medicaid block granting proponents look to President Reagan's implementation of block grants—including his desire to block grant Medicaid—along with a long line of other conservative leaders to justify block granting Medicaid.[61] An underlying motive of these leaders in proposing such a change is the belief that the Medicaid program is outgrowing its ability to be effective.[62] But the Medicaid block grant proponents' comparisons to successful block grants and the acknowledgement of past intent both ignore crucial distinctions between developmental and redistributive policy.[63] The new freedom given to the states from block grants will not enhance as much as it will erode the effectiveness of the Medicaid

59. *See id.* at 4; KATCH, *supra* note 56, at 1.

60. *See* Bagley, *supra* note 47, at 24.

61. *See* A BETTER WAY, *supra* note 1, at 25.

62. *See* Lambrew, *supra* note 1, at 42–43. Lambrew provided historical context, stating:

> Since its beginning, the United States has struggled to balance nation and state responsibilities. From President Franklin D. Roosevelt's New Deal in the 1930s through President Lyndon B. Johnson's Great Society in the 1960s, the proponents of a common, national interest prevailed. . . . Then Ronald Reagan changed this trend, bringing back the idea of states' taking responsibility for welfare programs. His rationale was that the states are more likely to be efficient and innovative because they are both closer to the people and held more accountable by them . . . ."

Id.

63. *See* Paul E. Peterson, *Devolution's Price*, 14 YALE L. & POL'Y REV. 111, 112–13 (1996) ("For the same reason that local governments are well-suited to providing economic development—the mobility of labor and capital—they are not effective at redistributing wealth.").

program as a safety net for the poor, thereby contributing to a decline in the benefits available to beneficiaries.[64]

Historically, according to Professor Paul Peterson, "states and localities have assumed primary responsibility for managing the physical and social infrastructure—roads, education, mass-transit systems, public parks, police and fire services, and sanitation systems—necessary for the country's economic growth."[65] These developmental policies are best suited for and most effective at the local level because they involve concerns of local residents and businesses.[66] Redistributive policy, on the other hand, involves the shifting of resources from one group to another group in need of such resources (e.g., single parents, the disabled, the elderly, the unemployed, the sick, the poor, etc.) and is most effectively implemented by the expansive reach of a national government.[67]

64. *See* EDWIN PARK & JUDITH SOLOMON, CTR. ON BUDGET & POL'Y PRIORITIES, PER CAPITA CAPS OR BLOCK GRANTS WOULD LEAD TO LARGE AND GROWING CUTS IN STATE MEDICAID PROGRAMS 3 (2016), http://www.cbpp.org/sites/default/files/atoms/files/6-22-16health.pdf [hereinafter BLOCK GRANTS] ("The flexibility apparently would eliminate various federal beneficiary protections and key federal minimum standards related to who may qualify for Medicaid and which essential health services the program must cover.").

65. *See* Peterson, *supra* note 63, at 112.

66. *See id.* at 112–13.

67. *See id.* at 113 ("The smaller the territorial reach of a local government, the less its capacity for redistribution."). There is evidence, however, that suggests that second-order devolution (or the process whereby a state further devolves their welfare authority to local level governments) has an led to a higher number of people transitioning off of welfare. *See* Byungkyu Kim & Richard C. Fording, *Second-Order Devolution and the Implementation of TANF in the U.S. States*, 10 ST. POL. & POL'Y Q. 341 (Winter 2010). The study's authors specifically found that "[a]fter controlling for several socioeconomic and political variables, we find that TANF programs in [second-order devolution] states display significantly better employment outcomes for two of our three measures of performance*: employment exists* and *average earning gain*." *Id.* at 361. Other research has found that the professionalism of those implementing a devolved welfare program along with the perceptions of empowerment the local implementation networks received led to effective welfare program implementation. *See* Chung-Lae Cho et al., *Translating National Policy Objectives into Local Achievements Across Planes of Governance and Among Multiple Actors: Second-Order Devolution and Welfare Reform Implementation*, 15 J. PUB. ADMIN. RES. & THEORY 31, 49 (2005); *see also* Michael Craw, *Caught at the Bottom? Redistribution and Local Government in an Era of Devolution*, 47 ST. & LOC. GOV'T REV. 68, 73 (2015) ("The implication of this is that local responses to poverty are not uniformly antiredistributive, but rather are conditional on the degree to which taxable wealth is mobile and communities are fiscally independent. Local governments have greater autonomy in the social welfare realm when exit costs are higher or when they do not need to rely on local taxes to fund services. Given the influence of fiscal federalism over public finance, it is easy to overlook the significant amount of the provision and financing of social welfare functions that happens at the local level.").

These principles have been understood in the past; for example, President Reagan's block grant implementations focused on developmental programs such as community development and education and left redistributive programs such as food stamps, welfare, and Medicaid nearly untouched.[68]

Today's Medicaid block granting proponents are clearly missing the fundamental distinction between developmental and redistributive policy.[69] In a redistributive program, to qualify for Medicaid, states must meet certain requirements to receive federal funding.[70] These federal standards exist to *effect* the fundamental purpose of the redistributive policy of providing a safety net for the poor.[71] With the purpose of redistributive policy understood, requirements on states to cover certain mandatory populations, such as children up to age nineteen whose family's income is at or below 133% of the federal poverty line,[72] are reasonable because they *effect* the baseline scope of the redistributive program.[73] It also

68. *See* Peterson, *supra* note 63, at 115 ("Most importantly, Reagan cuts focused not on the safety net but on traditional public services. . . . At the same time, welfare, food stamps, and Medicaid policies were left virtually untouched. Overall, redistributive grants actually increased from 1.3% to 1.4% of GNP."); *see also* Lambrew, *supra* note 1, at 45 ("In explaining why Medicare was not included in Reagan's attempts to limit the federal government, an official described Medicare as one of the 'sacred' programs." (internal citation omitted)).

69. *See* Peterson, *supra* note 63, at 112–13. Peterson makes an important policy distinction, clarifying:

> The reluctance of state and local governments to participate in the redistributive movement can hardly be attributed to the political climate. Over most of this period Democrats controlled at least part of state government in most states, and they held unified control in several. Differences in state and local treatment of development and redistributive policies are rooted not in partisan politics but in underlying features of the federal system.

Id.

70. *See* Jon Donenberg, *Medicaid and Beneficiary Enforcement: Maintaining State Compliance with Federal Availability Requirements*, 117 YALE L.J. 1498, 1501 (2008) ("When states agree to participate in Medicaid, they must provide assurances that they will act 'in conformity with the specific requirements' of the federal Medicaid statute and applicable CMS regulations." (quoting 42 C.F.R. § 430.10 (2007))).

71. *See* 42 U.S.C. § 1396-1 (2012); Donenberg, *supra* note 70 at 1505 ("Medicaid uses both promise of federal funds and the threat of funding withdrawal to shape the coverage provided by individual states. By reducing the costs to states to provide particular services, federal matching funds facilitate new initiatives and coverage expansions.").

72. *See* NAT'L HEALTH POL'Y FORUM, THE BASICS: MEDICAID ELIGIBILITY AND BENEFITS 2 (2016), https://www.nhpf.org/library/the-basics/Basics_Medicaid_01-05-16.pdf [hereinafter THE BASICS: MEDICAID ELIGIBILITY AND BENEFITS].

73. Interestingly, states have a great deal of discretion in the manner in which they conduct their Medicaid programs' scope and structure. *See* Saundra K. Schneider,

makes sense out of the numerous other program requirements, such as the inclusion of mandatory benefits—hospitalization, physician visits, nursing home care, preventive care, screenings, testing, etc.[74]—as these are the requirements that *effect* the depth of the redistributive program.[75] States are forbidden from requiring anything but very low copayments of the beneficiaries for any of these services because such requirements are logically inconsistent with the need for a redistribution program.[76]

As states already have significant freedom in how they manage and provide for their Medicaid programs—even while adhering to the mandatory federal standards—the only real effectiveness that block grant flexibility might generate would likely be reforms that currently violate federal law.[77] Professor Stephen D. Sugarman suggested that these types of changes could come in two forms: (1) changes that are currently unconstitutional and (2) changes which might be constitutional but that states cannot currently obtain waivers from the federal government to implement.[78]

One example of an unconstitutional change would be a state's implementation of a two-tiered welfare system, with a beneficiary's

Intergovernmental Influences on Medicaid Program Expenditures, 48 PUB. ADMIN. REV. 756, 757 (1988). According to Schneider, states decide exactly who is eligible for Medicaid services, as states establish the eligibility standards for the federally mandated beneficiaries as well as decide whether to include optional populations. *Id.*

74. *See* THE BASICS: MEDICAID ELIGIBILITY AND BENEFITS, *supra* note 72, at 4–5.

75. *See* C. David Flower, *State Discretion in Funding Organ Transplants Under the Medicaid Program: Interpretive Guidelines in Determining the Scope of Mandated Coverage*, 79 MINN. L. REV. 1233 (1995) (highlighting the fact that the line is not clear as to what services are required to be covered by a state's Medicaid program beyond the statutorily mandated coverage); *see also* Schneider, *supra* note 73, at 757. Schneider also indicates that states can influence the structure (or depth) of their Medicaid program by indicating what optional services to provide (in addition to the federally mandated benefits) to its beneficiaries as well as their placement of "restrictions on the number, type, and mix of services that are covered." *Id.* States also decide how providers are reimbursed which includes defining "what are considered 'reasonable,' 'customary,' or 'allowable' charges." *Id.* Lastly, states decide who will implement the policy by deciding whether it will be administered at the state of local level. *Id.*

76. *See* THE BASICS: MEDICAID ELIGIBILITY AND BENEFITS, *supra* note 72, at 5–6.

77. *See* Sugarman, *supra* note 23, at 144–46.

78. *See id.* at 145 ("Therefore, in principle, the key objective that the block grant solution would accomplish would be to allow states to enact changes for which they cannot currently obtain waivers.").

tier placement determined by their time of residency.[79] Such a design would surely have as its intent to discourage welfare recipients from moving into the state, thereby promoting program effectiveness by rationing resources. The Supreme Court held in *Shapiro v. Thompson* that a waiting period for newcomers of a state to receive welfare benefits was unconstitutional[80] and would likely hold similarly in other situations, such as our example.[81] These types of attempts to promote program effectiveness rub against core constitutional protections, making them difficult to implement under an entitlement or block grant program.[82]

The second form of changes are those that are constitutional but for which a state cannot obtain a waiver under an entitlement program; these are the type of reforms that a block grant might allow. The history of the Aid to Families with Dependent Children (AFDC) entitlement program, and its transformation into the TANF block grant, provides an excellent example of the "effective" changes allowed within this program with the new state flexibility.[83]

As a federal entitlement, a state's AFDC program would have needed a waiver to depart from the federal guidelines. The reforms that a state would have a difficult time obtaining a waiver for are illustrated from the examples of AFDC waiver requests that were

79. *See id.* ("A good example is the strategy of high-benefit states to offer newcomers to the state lower welfare benefits than are paid to old timers.").

80. Shapiro v. Thompson, 394 U.S. 618, 631 (1969).

81. *See* Sugarman, *supra* note 23, at 145. Regarding this point, Sugarman cautioned:

> Nonetheless, the Bush Administration allowed Wisconsin to try it out on the ground that state officials should have the right to make a pitch to the current U.S. Supreme Court to abandon or limit *Shapiro*. The Clinton Administration, however, has refused to grant a waiver for this two-tier benefit strategy, and by the same token would also refuse to grant waivers for other experiments containing conditions that it considers to be unconstitutional under prevailing doctrine.

Id. (footnotes omitted)

82. *See Shapiro*, 394 U.S. at 631. The U.S. Supreme Court stated the following:

> Thus, the purpose of deterring the in-migration of indigents cannot serve as justification for the classification created by the one-year waiting period, since that purpose is constitutionally impermissible. If a law has "no other purpose . . . than to chill the assertion of constitutional rights by penalizing those who choose to exercise them, then it [is] patently unconstitutional.

Id. (quoting United States v. Jackson, 390 U.S. 570, 581 (1968)).

83. *See* LIZ SCHOTT, CTR. ON BUDGET & POL'Y PRIORITIES, WHY TANF IS NOT A MODEL FOR OTHER SAFETY NET PROGRAMS 1–7 (2016), https://www.cbpp.org/sites/default/files/atoms/files/6-6-16tanf.pdf.

ultimately rejected by the Clinton Administration.[84] The proposals received by the Clinton Administration included:

> (1) a complete separation from welfare after a maximum period (as contrasted with required public service work in lieu of a cash grant at such time); (2) submission to random drug testing as a condition of receiving welfare; and (3) strict sanctions in the form of immediate exclusion from welfare for non-cooperative behavior that now leads initially only to mild punishments.[85]

Such proposals might have had as their advertised and intended objectives an increased effectiveness by promoting incentives to become self-sufficient, rationing resources for the most deserving, or using discretion to allot resources to those who express appreciation through program obedience; however, under the redistributive terms of the federal entitlement, these requests were deemed outside the scope of the program's purpose, allowing the federal government to reject such proposals.[86]

The transfer of the AFDC entitlement to the TANF block grant came in the shadow of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.[87] This welfare reform act facilitated an ideological transition driven by the idea that welfare recipients now had to do something to get something, essentially

84. *See* Sugarman, *supra* note 23, at 145 ("A second group of changes that states might like to make, but for which they cannot . . . are those that the federal government will not now permit because, while the changes may be constitutional, nonetheless they are too inconsistent with the fundamental underlying purposes of the AFDC program.").

85. *Id.* at 145–46.

86. *See id.* at 139. Professor Sugarman believes that their advertised intentions were not their real intentions, explaining:

> [N]ot long ago the major failings of AFDC were seen by many in Washington to lie in inadequate benefits and demeaning administration. In view of our experience with other income transfer programs, the desirable direction of reform to solve those failings would be to enhance federal responsibility through the creation of a generous national benefit level managed by the social security administration. But that strategy assumed not only public empathy with these single parent families but also a willingness to enable the mothers in those families to care for their children without entering the paid labor force if they chose not to do so—exactly the way we now treat most widowed mothers, and have been treating them through social security since 1939.

Id. (footnote omitted).

87. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (1996); *see, e.g.*, Christine N. Cimini, *The New Contract: Welfare Reform, Devolution, and Due Process*, 61 MD. L. REV. 246, 246 (2002).

redefining the purpose of the redistributive program.[88] The TANF statute states as its purpose the providing of resources for children to be raised in their homes; however, it also departed from being an exclusive redistributive program by encouraging the elimination of parental dependence on government benefits by promoting job preparation, work, and marriage.[89] The statute also seeks to prevent and reduce out-of-wedlock pregnancies while also encouraging the formation and maintenance of two-parent families.[90]

The TANF program requires a recipient to be engaged in work (as defined by the state) within twenty-four months of receipt of assistance,[91] and to enter into an agreement with the government through an individual responsibility plan.[92] The TANF program also mandates a sixty-month cap on the receipt of benefits, with few exceptions.[93] The statute adds other requirements in furtherance of its objective that welfare recipients to do something to get something, including: job-search obligations, school-attendance

88. *See* Cimini, *supra* note 87, at 257 ("In the legislative hearings leading to the passage of the Welfare Reform Act, numerous legislators articulated their desire to change the existing entitlement model of welfare, under which recipients were perceived as getting something for nothing.").

89. *See* 42 U.S.C. § 601(a)(1)–(4) (2012).

90. *See id.*

91. *See id.* § 602(a)(1)(A)(ii).

92. *See id.* § 608(b)(2)(A). The specific requirements of the individual responsibility plans include the following subsections:

> (i) sets forth an employment goal for the individual and a plan for moving the individual immediately into private sector employment;
>
> (ii) sets forth the obligations of the individual, which may include a requirement that the individual attend school, maintain certain grades and attendance, keep school age children of the individual in school, immunize children, attend parenting and money management classes, or do other things that will help the individual become and remain employed in the private sector;
>
> (iii) to the greatest extent possible is designed to move the individual into whatever private sector employment the individual is capable of handling as quickly as possible, and to increase the responsibility and amount of work the individual is to handle over time;
>
> (iv) describes the services the State will provide the individual so that the individual will be able to obtain and keep employment in the private sector, and describe the job counseling and other services that will be provided by the State; and
>
> (v) may require the individual to undergo appropriate substance abuse treatment.

Id. § 608(b)(2)(A)(i)–(v).

93. *See id.* § 608(a)(7)(A)–(C).

goals for children, agreements to become self-sufficient, etc.[94] The individual responsibility plans vary by state, with some states having further devolved authority over these programs to local governments.[95] Consequently, these plans often suffer for a want of written rules,[96] with discrepancies in criteria and differing standards of enrollment common even within the same state.[97] Social workers, who previously only had a programmatic role for determining the criteria under the federal entitlement, now have broad authority to determine those eligible for the program.[98]

As the history of the TANF block grant illustrates, without federal entitlement protection, "effectiveness" can begin to encompass a variety of initiatives that are unrelated to redistributive policy. A similar ideological transition of purpose within the Medicaid program would be devastating for those dependent on its medical funding, making a Medicaid block grant a dangerous option for those who need it most.[99]

94. *See* Cimini, *supra* note 87, at 258 n.69.

95. *See id.* at 256.

96. *See id.* at 260 ("Actual implementation of the Welfare Reform Act has led to an increased absence of rules. In the administration of welfare programs, caseworkers now rely on guidelines that offer a range of options, as opposed to bright-line rules." (footnote omitted)).

97. *See id.* at 262–64.

98. *See id.* at 261 ("As compared to caseworkers under the AFDC system, who were mainly eligibility technicians, caseworkers are now asked to be vocational experts, child care specialists, and even mental health workers in order to assess and arbitrate the terms of an applicant's public benefits." (footnote omitted)). *But see* Juliet F. Gainsborough, *To Devolve or Not Devolve? Welfare Reform in the States*, 31 POL'Y STUD. J. 603, 617 (2003) (the author, after examining the devolution of TANF programs in the states, found that states that devolved welfare programs to the local level occurred only in states that already had locally administered programs). The author also stated: "The importance of the previous policy and its mobilization of local interests around welfare reform is illustrated by the lack of devolution that occurred in states without this history of local involvement in welfare policy." *Id.*

99. *See* Cimini, *supra* note 87 at 260. Cimini highlights four factors that lead to increased discretion in a welfare program, three of which are visible in the TANF block grant, and would be equally visible in a Medicaid block-grant program, stating:

> Scholars have identified a number of factors that lead to increased discretion and have found these factors to exist across the range of welfare administrative models. The factors include: an increased absence of actual rules to guide discretion, a change in the role of the welfare administrator from eligibility technician to contract negotiator, devolution of authority to state and local governments, and the privatization of previously public services.

Id.

Medicaid block granting opponents have already warned of the potential changes that might follow from implementing a Medicaid block grant, including: shifting beneficiaries into individual-market plans without assurances that the coverage would be adequate and affordable[100] or states establishing a work requirement to qualify for coverage (terminating coverage for those found to be noncompliant).[101] Additionally, states could charge premiums for most adults, use waiting lists or cap enrollment, and restrict or eliminate benefits now protected under federal law.[102] States would also be able to charge larger co-payments to beneficiaries and omit coverage of current mandatory services.[103] These proposed structural changes, similar in nature to the implemented TANF reforms, suggest an underlying ideological transition as well; this transition defeats both the historical and current statutory purpose of Medicaid—that of a redistributive welfare program providing a safety net for the poor.[104]

Because the purpose of providing state flexibility to increase state Medicaid effectiveness is incompatible with Medicaid's purpose of being a safety net for the poor, the purpose of state flexibility is likely driven by other motives.[105] As the block grant will eventually succumb to the rate of medical inflation, states will undoubtedly be forced to make many of the above concessions, using their flexibility to effectuate cuts to Medicaid recipients and benefits; consequently, the effectiveness of Medicaid will be limited

100. *See* BLOCK GRANTS, *supra* note 64, at 3–4. Specifically, under the Better Way or House Republican plan, insurers could eliminate benefits such as maternity care, prescription coverage, impose substantial deductibles, annual benefit limits, or other cost-sharing requirements. *Id.* Interestingly, with Congress' failure to repeal the ACA, many of these proposed changes are appearing as Section 1115 Waivers whereby a state can ask permission to implement a component of their Medicaid program that is outside of federal regulations. *See* MARYBETH MUSUMECI ET AL., KAISER FAM. FOUND., SECTION 1115 MEDICAID DEMONSTRATION WAIVERS: THE CURRENT LANDSCAPE OF APPROVED AND PENDING WAIVERS 3–6 (2018), http://files.kff.org/attachment/Issue-Brief-Section-1115-Medicaid-Demonstration-Waivers-The-Current-Landscape-of-Approved-and-Pending-Waivers.

101. *See* BLOCK GRANTS, *supra* note 64, at 4. Under the House Republican plan, states would be allowed to require the "able bodied adults" who are beneficiaries of Medicaid to show that they are looking for work, working, or in some other educational or training program. *Id.*

102. *See id.*

103. *See id.*

104. *See* 42 U.S.C. § 1396(a) (2012); Sugarman, *supra* note 23, at 144–46.

105. *See* MEDICAID IN THE UNITED STATES, *supra* note 20, at 1.

by inhibiting the breadth, scope, and depth of coverage available to beneficiaries—thereby exposing the medically vulnerable to unnecessary risks by undermining their programmatic rights.

C. State Innovation

Medicaid block grant proponents argue that state flexibility leads to innovation, which is at the heart of our federal system of government.[106] The policy behind this theory is that national programs, such as Medicaid, promote a uniform system that causes states to miss out on the opportunity to approach their program differently; consequently, this deprives the states of the opportunity to observe and implement other, possibly better, approaches.[107] Implicit in this idea is the prospect of states sharing information, leading to a state's abandoning of a particular approach in favor of a more efficient approach, with all states eventually coming to a national consensus that benefits the entirety of the system.[108]

Medicaid block grant proponents argue that different locations have different tastes and concerns, and the block grant would allow innovative tailoring to those concerns without the excesses of a national program.[109] With the control closer to the people, they

106. *See* A BETTER WAY, *supra* note 1, at 21 ("States have long been America's innovation hubs. One key to long-term market stability is giving states the flexibility to craft premium-reduction programs that support wellness and offer innovative plan designs.").

107. *See* Sugarman, *supra* note 23, at 140. Professor Sugarman has suggested the following:

> The argument here is that the national government too quickly imposes a uniform system, and so we lose the opportunity to learn from a diversity of approaches to a problem that individual states are likely to take (even though, of course, the federal government could itself deliberately engage in direct sponsorship of experimental solutions).

Id.

108. *See id.* ("The notion seems to be that once some states do experiment, others will observe the results and embrace the best solution for themselves. Hence, over time, one would expect a convergence on policies that prove successful.").

109. *See id.* ("Federalism is also often praised for providing variety in government, thereby giving people with different tastes reason to live in one locale or another—although this idea is traditionally more frequently applied to local variation, not so much to state-to-state variation.").

could theoretically block their local leaders from implementing changes they find unacceptable within such programs.[110]

Despite the promising potential, history has shown an absence of a direct correlation between the virtues of federalism and a tailored implementation of a social program.[111] For example, unemployment compensation, as a form of social insurance, is administered at the state level.[112] States differ in many respects as to both the scope and criteria to qualify for such benefits (e.g., some states allow employees to quit jobs because of a fear of future health consequences, others do not, etc.).[113] While such differences can be understood as experiments of federalism, they are more likely responses to the local business climate of the state.[114] This conclusion is supported further by the omission of any evidence that other states have actively sought out a best solution to model their unemployment compensation programs after (based on the successes of other states) or evidence that one approach has led to a national consensus on how to implement unemployment compensation.[115] It is hard to imagine that a Medicaid block grant would be an exception to history.

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110. *See id.* at 141 ("The idea here is that the closer government is to the people, the better able the people are to block their leaders from doing things that the citizenry doesn't really want, especially through tighter local control over government revenues (i.e., taxes).").

111. *See id.* at 142. Professor Sugarman cautions:

> In short, I do not read the record on state-run social insurance schemes as one that has either: (a) enabled states to experiment boldly and to act decisively based on the results of each other's experiments; or (b) permitted states to capture in their plans important cultural or value differences that may exist from state to state.

Id.

112. *See id.* at 141.

113. *See id.*

114. *See id.* ("There are differences, to be sure; differences that federalism permits, even encourages. But they do not seem properly understood as experiments or innovations. It is not as though states have mounted serious research efforts to decide which of these various paired solutions are somehow to be judged best and then conformed.").

115. *See id.* at 142 ("But, once again, the states simply do not seem to treat these diverse approaches as experiments that, after a suitable period of time and study, lead all, or most of them, to agree that one solution is best."). While causation is difficult to establish, correlation amongst the states' in the implementation of their welfare programs is well established. *See* Robert C. Lieberman & Greg M. Shaw, *Looking Inward, Looking Outward: The Politics of State Welfare Innovation under Devolution*, 53 POL. RES. Q. 215, 235 (2000) ("[Our results] suggest that states moved together in response to national welfare trends, and that when they chose to innovate they tended to do similar things, regardless of ideological, partisan, or other local and regional factors that might have pushed them in divergent directions."). Liberman and Shaw also found evidence of states' convergence of AFDC reforms from evidence that states

Notably, Medicaid is already innovative in numerous ways.[116] States have, for the last several decades, implemented coordination techniques such as managed-care plans that encompass a network of providers.[117] States have also implemented capitated-rate payments—eliminating the incentive to provide unnecessary services by providing the plan or provider a set amount per beneficiary—as opposed to pay-by-service plans.[118] Such coordinated and capitated plans can provide for payments based on the quality of service, thereby succeeding in both reducing unnecessary services and focusing on the overall health of the beneficiary.[119] States have also experimented with streamlining care for the most vulnerable of beneficiaries, helping them access timely care.[120]

Specific examples of states using flexibility to innovate their Medicaid program include Missouri's Health Homes initiative, under which care for beneficiaries with serious mental illness or

would cluster reforms together into single waivers allowing states to incorporate other states' reforms into their waiver requests and that states did "not seem to have behaved as if they were trying to differentiate themselves from each other." *Id.* at 235. Research has found that states often realign themselves with national priorities in times of budgetary shortfalls. *See* Michael R. Sosin, *Decentralization, Devolution, Financial Shortfalls, and State Priorities in Service Programs in the Early 2000s*, 22 J. PUB. RES. & THEORY 701, 725 (2012).

116. *See* KATCH, *supra* note 56, at 1 ("Well before health reform expanded Medicaid coverage for millions of low-income adults, states began changing how they deliver Medicaid services to help ensure that beneficiaries receive appropriate, timely, and cost-effective care.").

117. *See id.* at 3 ("Many states now rely on managed care plans to develop networks of providers, ensure that beneficiaries have access to primary care providers, and help beneficiaries coordinate their care.").

118. *See id.* Hannah Katch, from the Center on Budget and Policy Priorities, has stated the following as another example of state innovation:

> Rather than paying providers for each service, which may create an incentive to furnish unnecessary, costly services, states pay a capitated rate, where a plan or provider receives a set amount per beneficiary and is responsible for their care. If payments are set at sound levels, this method can encourage plans and providers to provide the appropriate level of services to keep people healthy while avoiding unnecessary services, which can otherwise drive up costs.

Id.

119. *See id.*

120. *See id.* at 4 ("In addition to helping individuals navigate the various services they need, states are integrating the design of these services to streamline care for their most vulnerable beneficiaries. Providers are improving communication and data-sharing techniques to help beneficiaries access appropriate and timely care across multiple systems.").

chronic physical health conditions, treated in a home setting, has reduced the number of emergency room visits and preventable hospitalizations.[121] The implementation of Health Homes in Missouri led to a monthly savings of $52 dollars per Medicaid participant.[122] Similarly, Tennessee is one of many states that has implemented the Money Follows the Person program—aimed at transitioning Medicaid beneficiaries from nursing homes to their own home, the home of a caregiver, or a community residential facility.[123] Tennessee estimates that it spends close to half, or $1,969 of the $3,710 required to provide beneficiary nursing home accommodations, by transitioning the beneficiary to one of the alternative residences.[124]

Approved Medicaid experimentation can also foster innovation, as evidenced by Wisconsin's receipt of a Center for Medicare and Medicaid Innovation (CCMI) grant, a program which assists children beneficiaries whose complex medical needs result in high medical costs.[125] This coordinated service streamlines outpatient

121. *See id.* at 4 ("These services include comprehensive care management, care coordination, support transitioning between institutions or from an institution to the community, and referral to community and social services.").

122. *See id.* at 5.

123. *See id.* Hannah Katch explained further the benefits of the Tennessee program, stating:

> Many people in nursing facilities don't need the level of care the facilities provide but can't return to the community because they lack a home or the support they need to stay in their home. To address this problem, states are rebalancing Medicaid long-term services and supports away from institutional care in favor of home- and community-based services that help people return to or remain in a community setting.

Id.

124. *See id.* at 5–6 ("Between October 2011 and June 2013, more than 620 beneficiaries transitioned to the community through the program. It has produced significant state savings by reducing unnecessary nursing facility stays.").

125. *See id.* at 6. The specific incentives of this program include the following:

> Health reform established the Center for Medicare and Medicaid Innovation (CMMI) to test new health care payment and delivery models. One model offers a new way to provide care for children with complex medical needs, a rapidly growing group who tend to have very high health care costs and have hospital readmission rates equal to or higher than seniors who are Medicare beneficiaries. Community-based pediatricians often struggle to meet their needs, and these children and their families often must coordinate care from many different providers—especially when their hospital care is entirely separate from care available in their community.

Id. (footnotes omitted).

care and coordination, having resulted in both inpatient-hospital days and costs decreasing by 50%.[126] Further successful experimentation can be found in Oregon's accountable-care organizations.[127] Established through a Medicaid Section 1115 waiver, these accountable-care organizations coordinate medical needs as well as social needs (such as finding housing) by working with community organizations to meet the needs of Medicaid beneficiaries.[128] Oregon's largest accountable-care organization, Health Share, achieved in its first operational year an 18% reduction in emergency room visits.[129] Further, it found 80% of its members successfully enrolled in a specified medical home, and it earned 100% of its conditional quality-measurement payments were earned from the federal government.[130]

These examples of successful local tailoring highlight the fact that federalism is already at work within Medicaid. Medical needs are not so drastically different across the states to justify the shift in power Medicaid block grant proponents suggest is needed. In fact, implementation of a block grant would significantly impede much of the progress that states have made in providing streamlined and innovative Medicaid services to beneficiaries without compromising their programmatic rights. By implementing a Medicaid block grant, states would be forced to make substantive cuts as opposed to continuing efforts to innovate the delivery of Medicaid to beneficiaries.[131]

126. *See id.* ("Evaluation of this and similar models shows that participants are significantly more likely to report that their children's health needs were being met, and children were more likely to attend primary care checkups and receive scheduled therapies, mental health care, and respite care.").

127. *See id.* at 6–7.

128. *See id.* at 7 ("Oregon established a network of ACOs using a broad federal waiver (known as a section 1115 demonstration) that allows the Department of Health and Human Services to waive statutory requirements to permit testing of innovative state or local models or programs.").

129. *See id.* at 7–8.

130. *See id.*

131. *See* MEDICAID IN THE UNITED STATES, *supra* note 20.

II. PROMOTION OF STATE FISCAL PRUDENCE

Medicaid is the third largest domestic program in the federal budget,[132] and has grown significantly under the Affordable Care Act, covering nearly seventy-four million people in 2017.[133] As previously mentioned, the federal government picks up, on average, 57% to 60% of the states' costs.[134] With other groups, such as the ACA expansion population, the federal government will pay 90% of states' costs after 2020.[135] Ideas that this level of spending is unsustainable are not unfounded, as federalism scholar Robert Greenstein has said:

> We face, as a nation, severe, long-term fiscal problems. We face a collision between rising costs for elderly entitlements and a shrinking revenue base. . . . Over time, some things, many things have to give. And I think block grants are attractive to some policy makers, as a way over a long period of time to squeeze funding for some of the big low-income programs, relative to what it would be under the current entitlement funding structures and it enables it to do it without looking heartless by proposing to throw x-numbers of people over the side in program A, B, or C.[136]

Proponents of Medicaid block grants surely believe that cuts need to be made, with block granting being a solution.[137] The House Republican plan for the fiscal year 2017 would have saved the federal government one trillion dollars over ten years by implementing a Medicaid block grant, relative to current law.[138]

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132. *See* MEDICAID FINANCING: THE BASICS, *supra* note 6, at 1.

133. *See* MEDICAID IN THE UNITED STATES, *supra* note 20; *see also* INTRODUCTION TO MEDICAID, *supra* note 6, at 1 ("In any given month, Medicaid served 33 million children, 27 million adults (mostly in low-income working families), 6 million seniors, and 10 million persons with disabilities, according to Congressional Budget Office (CBO) estimates.").

134. *See* INTRODUCTION TO MEDICAID, *supra* note 6, at 4.

135. *See* MEDICAID FINANCING: THE BASICS, *supra* note 6, at 2.

136. *See* BLOCK GRANTS: PERSPECTIVES AND CONTROVERSIES, *supra* note 15, at 8 (citation omitted).

137. *See* Edwin Park, *Report: State Medicaid Enrollment Cuts Would Be Steep Under House Bill*, CTR. ON BUDGET & POL'Y PRIORITIES (June 19, 2017, 1:00 PM), https://www.cbpp.org/blog/report-state-medicaid-enrollment-cuts-would-be-steep-under-house-bill.

138. *See* MEDICAID BLOCK GRANT WOULD SLASH FEDERAL FUNDING, *supra* note 14, at 2–3 ("Moreover, the actual cut in federal funding for states, relative to current law, would be even greater in years when either enrollment or per-beneficiary health care costs rose faster than expected.").

Medicaid block grant proponents argue that block granting funding will promote long-term planning, eliminate unnecessary and wasteful duplication among other programs, and eliminate uncontrollable spending.[139] While these are the right objectives, they are not best satisfied by implementing a block grant due to the current state economic benefits received from Medicaid, state constraints on securing additional funding for social programs, and the implementation of a better approach that may reduce downstream costs and produce immediate economic benefits by expanding, versus contracting, coverage. This Part will conclude that the benefits of providing early Medicaid treatment to a larger population will best promote effective long-term planning, the streamlining of program (or treatment) objectives, and most effectively eliminate uncontrollable spending.

A. Medicaid Block Grant Impact on State Budgets

While Medicaid is a significant spending item on a state budget, it is also the largest source of federal revenue for states, accounting for more than half of all federal funds for 2015.[140] Medicaid is responsible for one of every six dollars spent on healthcare nationwide.[141] The insertion of federal money into the state economy has a multiplier effect, not only paying the services of providers, but indirectly benefiting community businesses and industries.[142] Illustrating this idea, Medicaid spending for 2009 accounted for the following national averages: 16% of all total health services and supplies, 18% of hospital care, 8% of professional services, 33% of nursing home care, and 8% of prescription drug spending.[143] Equally as important, many public hospitals, children's hospitals, and rural community health centers depend on Medicaid revenue, including Medicaid Disproportionate Share

139. *See* BLOCK GRANTS: PERSPECTIVES AND CONTROVERSIES, *supra* note 15, at 7–8.

140. *See* MEDICAID FINANCING: THE BASICS, *supra* note 6, at 8 ("In FY 2015, Medicaid accounted for 28.2 percent of total state spending for all items in the state budget, but 18.7 percent of all state general fund spending, a far second to spending on K–12 education (35.6 percent of state general fund spending).").

141. *See id.* at 1.

142. *See id.* at 8.

143. *See* IMPLICATIONS OF A FEDERAL BLOCK GRANT FOR MEDICAID, *supra* note 6, at 5 fig.7.

Hospital payments, which allow the hospitals to serve a large amount of low-income patients.[144]

As block granting Medicaid would not only limit the total number of beneficiaries but would also have economic repercussions in states, expanding Medicaid should be favored in an effort to promote the current multiplier effects from Medicaid's federal funding.

B. State Restrictions

Opponents of Medicaid block granting also point to two restrictions on states' ability to make up shortfalls in federal funding. These restrictions—when combined with block grant deficits—practically guarantee future cuts to enrollment and benefits and would most likely result in a state's inability to implement programs of equivalent entitlement quality.[145]

The first state restriction is what is referred to as the "Countercyclical Trap."[146] This occurs when, for example, a recession hits, resulting in many people losing their employer-sponsored insurance, which requires them to enroll in programs like Medicaid.[147] This results in larger federal outlays while, simultaneously, the economic recession lowers tax revenues.[148] In these types of situations, most state governments are not allowed to deficit-spend.[149] In contrast, the federal government can preserve the purpose of the program—providing a safety net for the poor—through its ability to deficit spend.[150]

All states (except Vermont) are required to balance their budgets annually.[151] Therefore, a state would be foolish to adopt a Medicaid program as expansive as that under the federal entitlement, only to have a recession force them to make cuts to

144. *See id.* at 5.

145. *See* Bagley, *supra* note 47, at 3–4.

146. *See id.* at 10; *see also* Lambrew, *supra* note 1, at 59 ("[I]t is unlikely that the current level of Medicaid enrollment could be sustained under most block grant policies.").

147. *See* Bagley, *supra* note 47, at 10 ("When a recession hits . . . [t]he ranks of those eligible for Medicaid and for ACA subsidies will predictably grow, leading to larger federal outlays.").

148. *See id.*

149. *See id.*

150. *See id.*

151. *See id.* at 10–11.

eligibility and benefits.[152] State solutions to a recession, such as raising taxes or cutting benefits, would likely only accelerate the recession.[153] From this standpoint, it not only makes sense, it is also necessary to have the federal government retain control over Medicaid to be able to account for the uncertain economic times ahead and to keep Medicaid consistent with its purpose as a safety net for the 19% of the United States population that relies on it.[154]

The second restriction on states is a federal law—the Employee Retirement Income Security Act of 1974 (ERISA)—which arguably prohibits states from creating laws requiring or punishing employers in their refusal to expand health coverage to their employees.[155] Specifically, ERISA preempts state laws that relate to an employee's benefit plan,[156] which likely prohibits states from requiring employers to offer health insurance to their employees.[157]

152. *See id*. at 11. Bagley explains this concept further with the following example:

> As the exception that proves the rule, Massachusetts is instructive. When it adopted statewide reform, Massachusetts had two advantages that no other state had. First, it had the lowest rate of uninsured in the country, meaning that its countercyclical obligations would be more modest than those of other states. Second, with the help of Senator Ted Kennedy, the state got a sweet-heart deal from the George W. Bush Administration offering it more than $1 billion in Medicaid funding to support a coverage expansion. Massachusetts could afford to bite the bullet. States without those advantages cannot—at least without the help from the federal government.

Id. (footnotes omitted).

153. *See id*.

154. *See* MEDICAID IN THE UNITED STATES, *supra* note 20, at 1 (demonstrating the breadth of coverage the current federal Medicaid program provides).

155. *See* 29 U.S.C. § 1144(a) (2012); Bagley, *supra* note 47, at 12–15.

156. *See* Gobeille v. Liberty Mut. Ins. Co., 136 S. Ct. 936, 943 (2016) (indicating that state laws that have a "reference to" or an "impermissible connection to" ERISA will be preempted); *see also* Bd. of Trs. of Glazing Health & Welfare Tr. v. Chambers, 903 F.3d 829 (9th Cir. 2018) (holding that the debt collection law limiting the amount of damages collectible from general contractors for debts of subcontractors as a traditional state function and not subject to ERISA preemption).

157. *See* EMP. BENEFITS SECURITY ADMIN., U.S. DEP'T LABOR, MULTIPLE EMPLOYER WELFARE ARRANGEMENTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA): A GUIDE TO FEDERAL AND STATE REGULATION 7 (rev. Aug. 2013), https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf (indicating that "virtually any type of health plan" will qualify as a benefit under a "welfare plan," making it subject to ERISA preemption). There is an unresolved circuit split on this issue. *See* Golden Gate Rest. Ass'n v. City & Cty. of San Francisco, 546 F.3d 639, 655–56 (9th Cir. 2008) (upholding an ordinance mandating the taxing of employers who failed to provide health insurance by reasoning that an employer who paid the tax wasn't intruding on ERISA); Retail Indus.

Notwithstanding this, it is unlikely that Congress will use its only remedy available—amending the ERISA law—as powerful lobbies are certainly resistant to such an idea.[158] In effect, states are powerless to implement any form of a replacement equivalent to the federal entitlement if block granting Medicaid were to occur, making it necessary to keep Medicaid as a federal entitlement if it is to stay true to its intended purpose.

C. A Fiscally Conservative Approach

Recent studies have analyzed the effects of the expanded Medicaid coverage for different populations, the resulting effects on those populations' economies and beneficiaries, as well as the cost to implement the Medicaid program itself.[159] The findings suggest large downstream savings by providing early treatment to beneficiaries as well as immediate economic benefits from insuring the uninsured through the influx of federal funding.[160] An expansion of these studies' concepts, compared with the consequences of uncompensated care a lack of coverage creates, provides support for the idea that block granting Medicaid would exacerbate exactly what its proponents suggest it would solve. Therefore, to meet both conservative and liberal Medicaid objectives, Medicaid should be expanded due to the long-term savings it may provide, the potential of immediate and long-term economic benefits provided, and the impact such expansion could have on Medicaid beneficiaries and society.

1. Long-term savings

New studies have focused on the downstream costs associated with different treatment options, most recently regarding drugs

Leaders Ass'n v. Fielder, 475 F.3d 180 (4th Cir. 2007) (striking down a law in Maryland similar to the law in *Golden Gate Restaurant Association*).

158. *See* Bagley, *supra* note 47, at 12.

159. *See* Nirosha Mahendraratnam et al., *Prescription Drug Utilization and Reimbursement Increased Following State Medicaid Expansion in 2014*, 23 J. MANAGED CARE & SPECIALTY PHARMACY 355 (2017) [hereinafter *Prescription Drug Utilization and Reimbursement*]; Zobair Younossi et al., *Treating Medicaid Patients with Hepatitis C: Clinical and Economic Impact*, 23 AM. J. MANAGED CARE 107 (2017) [hereinafter *Treating Medicaid Patients with Hepatitis C*].

160. *See Prescription Drug Utilization and Reimbursement*, *supra* note 159, at 355; *Treating Medicaid Patients with Hepatitis C*, *supra* note 159, at 107.

treating the hepatitis C virus (HCV).[161] In a study published in *The American Journal of Managed Care*, researchers examined differing state Medicaid policies for the treatment of HCV (i.e., some states offering coverage at most stages of disease progression, others not offering any coverage, others still determining what they would offer, and some states only offering Medicaid treatment for HCV at advanced fibrosis).[162]

The study found that most state Medicaid policies delayed treatment of HCV until it reached an advanced stage, with many only receiving treatment when the beneficiary transferred to Medicare.[163] This delay added significantly to the difficulty of the treatment, as the disease had often advanced to a more critical stage.[164] The study also found other systematic flaws, including the fact that when the HCV Medicaid population aged into Medicare the needed Medicare-level drugs had much less favorable discounts as compared to Medicaid (had they been approved for the beneficiary), thus increasing the costs to Medicare by treating a more advanced version of the disease at a more expensive rate.[165] The study highlighted the financial impact of these policies by mentioning that the average HCV liver transplant costs $188,000 and stating that "[t]he current Medicaid strategy was estimated to result in 27,000 excess cases of cirrhosis and almost 10,000 excess cases of decompensated cirrhosis, leading to over 1700 liver transplants, nearly 8000 cases of HCC [hepatocellular carcinoma

161. *See Treating Medicaid Patients with Hepatitis C*, *supra* note 159, at 107.

162. *See id.* at 110. The study that the authors used as the basis of the Hepatitis information in the article provides important information on the variety of policies states use to treat this disease. *See* Soumitri Barua et al., *Restrictions for Medicaid Reimbursement of Sofosbuvir for the Treatment of Hepatitis C Virus Infection in the United States*, 163 ANNALS INTERNAL MED. 215, 219 (2015) ("Of the 42 states, including the District of Columbia, with known Medicaid reimbursement criteria for sofosbuvir, 81% (n = 34) restrict reimbursement on the basis of liver disease stage . . . . In 4 states (10%), reimbursement is restricted only to persons with cirrhosis . . . . In two thirds of states (n = 27), sofosbuvir reimbursement is restricted to persons with advanced fibrosis . . . or cirrhosis . . . . In 2 states (5%), reimbursement is also provided for those with moderate fibrosis . . . and in 1 state for mild fibrosis . . . . In the remaining states, no reimbursement criteria are based on disease state (n = 8 [19%]).").

163. *See Treating Medicaid Patients with Hepatitis C*, *supra* note 159, at 110.

164. *See id.*

165. *See id.*

(liver cancer)], and over 16,000 HCV-related deaths."[166] The study's authors believed that HCV coverage should be provided earlier to all HCV Medicaid beneficiaries, which would not only save Medicare money but would improve the quality of life for many HCV beneficiaries.[167]

The study noted that the drawback of covering all HCV Medicaid beneficiaries would be the requirement of a sizeable amount of up-front money to finance such medications and procedures.[168] However, the study also found that treating all HCV Medicaid beneficiaries with an early intervention HCV medication, regardless of what disease development stage the HCV beneficiary was in, had significant consequences.[169] Specifically, the study estimated that with early intervention treatments there would have been "36,752 fewer cases of cirrhosis; 1739 fewer liver transplants; 8169 fewer cases of hepatocellular carcinoma; 16,173 fewer HCV-related deaths; 0.84 additional life-years per patient; and 1.03 additional quality-adjusted life-years per patient."[170] The financial consequences of this proposal would have resulted in a 39.4% ($3.8 billion) Medicare savings, consequently decreasing the down-stream treatment costs by 18.3%.[171]

The results from *The American Journal of Modern Care* study provide a foundation for two conclusions regarding the fiscal

166. *Id.* at 107–10.

167. *See id.* at 111. The study advocates a position that is in direct contrast to the principles of a Medicaid block grant, as the study notes:

> Institution of a less restrictive "treat all" strategy in Medicaid patients was associated with clinical outcome and cost benefits. Based on these data, we believe it is time to develop a national strategy to eradicate HCV from the United States regardless of payer status. Such a strategy requires collaboration among private payers, governmental payers (including Medicaid), healthcare providers, drug manufacturers, and patients.

Id.

168. *See id.* The authors of the study acknowledge an immediate hurdle to implementing their proposal, but suggest:

> Given the large number of patients with HCV, we acknowledge that such a strategy would require up-front investment in the context of state Medicaid budget constraints; however, this strategy would ultimately lead to cost savings for CMS by reducing the future burden to Medicare and the costs associated with HCV morbidity and mortality.

Id.

169. *See id.* at 107.

170. *Id.*

171. *See id.*

analysis of a Medicaid block grant. First, while this study focused exclusively on the delayed treatment of HCV, it reasonable to suggest that high Medicaid and Medicare costs can also be attributed to the delayed treatment of other diseases in addition to HCV.[172] This information provides a powerful argument for those looking at the fiscal impact of the Medicaid and Medicare programs on the federal budget by suggesting that the most fiscally responsible policy would be to adjust internal Medicaid policies to allow for early treatments of HCV and other diseases.[173] Consequently, adjusting internal Medicaid policies to allow for earlier treatments of a variety of diseases would trade more up-front money for exponentially greater future savings.[174] This first

172. *See, e.g.*, CTR. FOR STRATEGIC PLANNING, DEP'T HEALTH & HUMAN SERVS., PATIENT PROTECTION AND AFFORDABLE CARE ACT SECTION 4108: MEDICAID INCENTIVES FOR PREVENTION OF CHRONIC DISEASES (MIPCD) 5 (Feb. 23, 2011), https://innovation.cms.gov/Files/fact-sheet/MIPCD-Funding-Opportunity-Announcement.pdf ("Interventions that address the behavioral or social circumstances that influence participation in preventive health services and/or otherwise have a positive impact on outcomes of preventive health services may contribute to improving health and decrease growth in health care expenditures."); Jonathan C. Javitt et al., *Preventative Eye Care in People With Diabetes Is Cost-Saving to the Federal Government*, 17 DIABETES CARE 909, 912 (1994) (finding that if all patients were to receive recommended ophthalmological care, it would result in a $427.1 million dollar annual savings (1994) to the federal government).

173. *See Treating Medicaid Patients with Hepatitis C*, *supra* note 159, at 108 ("It has been well established that universal, immediate treatment with these all-oral, interferon-free highly effective targeted regimens is cost-effective and decreases downstream medical costs, due primarily to the avoidance of liver-related complications. Furthermore, in the United States, marketplace competition has reduced the net cost of these drugs as manufacturers provide substantial discounts for Medicaid patients. Despite these factors, a recent study from the TRIO registry found that Medicaid was the least likely payer to cover HCV treatment."). Ten states participated in the Section 4108 program by creating programs that targeted early prevention of chronic diseases by implementing programs that were gauged to change behaviors that increased susceptibility to chronic disease. *See* RTI INT'L, CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID INCENTIVES FOR PREVENTION OF CHRONIC DISEASES 75–76 (Apr. 2017), https://downloads.cms.gov/files/cmmi/mipcd-finalevalrpt.pdf [hereinafter MEDICAID INCENTIVES] ("The MIPCD States demonstrated that they and other States can successfully implement incentive programs in Medicaid, although implementing these programs was more challenging and required significantly more time planning and greater flexibility in implementing than States originally anticipated. Clearly, the saying, 'build it and they will come' does not translate into a successful Medicaid incentive program—just providing incentives for adopting healthy behaviors was not sufficient. States struggled with delays in implementing programs and in getting participants to enroll, resulting in only two States (Hawaii and Texas) reaching their enrollment targets. Collectively, actual enrollment was about 70 percent of target enrollment.").

174. *See Treating Medicaid Patients with Hepatitis C*, *supra* note 159, at 111 ("Given the large number of patients with HCV, we acknowledge that such a strategy would require up-

conclusion also suggests that block granting Medicaid would be fiscally irresponsible simply because it would impede early intervention of (presumably less expensive) treatments with likely cuts to enrollment and benefits.[175]

Second, adjusting Medicaid and Medicare's external policies to allow for expanded medical coverage of the uninsured—combined with the early treatments of the first conclusion—could provide significant savings to the federal government.[176] For example, the earlier potential beneficiaries get covered under Medicaid, the sooner they can seek presumably less expensive preventative care

front investment in the context of state Medicaid budget constraints; however, this strategy would ultimately lead to cost savings for CMS by reducing the future burden to Medicare and the costs associated with HCV morbidity and mortality."). For a variety of diseases, the major difficulty is going to be how to provide the necessary incentives to motivate beneficiaries to engage in preventive care—as preventive care will not always be about accessibility to a medication. *See* MEDICAID INCENTIVES, *supra* note 173, at 255–56 ("Looking at the benefit chain, we first know from the analysis of MIPCD State MDS in Section 4 that incentives increase the use of preventive services for most of the programs' target areas (Table 9-1). Thus, the necessary, but not sufficient condition for improvements in short-term health outcomes is met. Second, the State evaluation reports provide mixed evidence about whether incentives lead to improvements in short-term health outcomes. In diabetes prevention programs, incentives were associated with significantly higher percentages of participants reaching weight loss goals in two of the three States measuring this variable, but the average weight loss did not differ significantly between the incentive and control groups in these States. Incentives seemed to have a clearer effect on smoking cessation rates: cessation rates were higher for the incentive group in four of the five States that focused on smoking cessation. The improvement in cessation rates ranged from 4.0 to 9.8 percentage points. Incentives appeared to have no effect on short-term outcomes for blood pressure, although only a couple of State programs assessed this outcome. In Texas, the wellness program was associated with a significant improvement in a common measure of overall health."). This might be a partial solution to the high costs associated with super-utilizers. *See* JOSHUA M. WIENER ET AL., KAISER FAM. FOUND., STRATEGIES TO REDUCE MEDICAID SPENDING: FINDINGS FROM A LITERATURE REVIEW 7 (June 2017), http://files.kff.org/attachment/Issue-Brief-Strategies-to-Reduce-Medicaid-Spending-Findings-from-a-Literature-Review ("Medicaid programs, health systems, and communities are experimenting with efficient and effective approaches to identifying and engaging with high-cost, high-use enrollees, commonly referred to as super-utilizers. The expectation is that targeted, often intense care management of these individuals will lead to reductions in unnecessary use and greater connections to needed community-based resources. Controlling costs in this population can have a significant impact on total Medicaid spending given that an estimated 5% of Medicaid beneficiaries with complex medical and psychosocial needs account for 54% of total Medicaid spending.").

175. *See supra* Part I.

176. *See Treating Medicaid Patients with Hepatitis C*, *supra* note 159, at 110 ("Under the current scenario of Medicaid LDV/SOF restrictions, the total costs of treating the HCV cohort totaled $9.7 billion, with the majority of costs (50.4%) attributable to downstream costs of care (ie, [sic] hospitalization costs, outpatient costs, and non-LDV/SOF pharmacy costs).").

or treatments, reducing downstream costs to both Medicaid and Medicare.[177] This would allow more people to enter Medicare having been previously covered under Medicaid, resulting in the per-beneficiary costs of Medicare being reduced.[178] In sum, this second conclusion is an excellent example of effective, long-term planning, the streamlining of inefficient or duplicative programs, and the limiting of uncontrollable spending.

2. Economic benefits

A study in *The Journal of Managed Care & Specialty Pharmacy* found that after a one-year period, states that had implemented the ACA Medicaid expansion realized a 17% increase in prescription drug usage and a 36.1% increase in prescription reimbursements compared to the quarter before expansion.[179] Additionally, of the eight Medicaid expansion states surveyed, they collectively averaged both a 1.4 million prescription-per-quarter and a $163 million dollar-per-quarter increase in utilization and reimbursement compared to the change in rates of the ten nonexpansion states surveyed.[180]

These findings suggest Medicaid expansion allows patients who were previously uninsured to have access to needed

177. *See id.* ("Although the largest cost savings were attributable to downstream medical cost offsets, pharmacy costs attributable to LDV/SOF treatment decreased 2%, from $4.84 billion to $4.75 billion; this is due in part to the 9618 patients potentially eligible for LDV/SOF 8W treatment under Medicaid at the onset of the model who age into Medicare as compensated cirrhotics and can only receive treatment with the 12W regimen. Additional LDV/SOF cost savings result from treating a larger number of patients under Medicaid and the lower price for LDV/SOF under this scheme versus Medicare ($31,500 vs $83,108.18 [inflation-adjusted future price] for LDV/SOF 8W.").

178. *See id.* ("Under the current scenario of Medicaid LDV/SOF restrictions, the aggregate cost per SVR across the entire patient cohort—patients treated in Medicaid, patients treated in Medicare, and patients unable to be treated—was $51,809. Treating all Medicaid patients with LDV/SOF led to a 19.8% ($10,282) savings per SVR and was dominant from a cost-effectiveness (cost per life-year gained, cost per QALY gained) standpoint, given that earlier treatment with LDV/SOF resulted in better health and cost outcomes.").

179. *See Prescription Drug Utilization and Reimbursement*, *supra* note 159, at 359.

180. *See id.* at 357. "Conversely, the nonexpansion states studied saw a 2% decrease in prescription drug usage with a 6.3% increase in prescription drug reimbursement in the same time frame." *Id.* at 359.

prescription drugs;[181] similarly, these findings also suggest that increased utilization of prescription drug usage and reimbursement occurs as individuals have access to health insurance.[182] While this study was specifically limited to the pharmaceutical industry, the successes of prescription drug reimbursement through Medicaid expansion ought to incentivize further studies of the correlations of health access, health outcomes, and corresponding economic outcomes.[183] Notwithstanding the conclusions such research might yield, the current prescription drug use and reimbursement results from expanding coverage provide a strong argument to expand health insurance access due to its beneficial impact on both beneficiaries and state healthcare industries.

On a more intimate level, expanding Medicaid coverage is likely to produce economic effects that improve the quality of life of beneficiaries.[184] Specifically, a study that sought to determine the effect of Medicaid expansion on personal bankruptcies "found a

181. *See id.* ("[T]he increased rate of prescriptions per quarter in the expansions states in the period after expansion suggests that Medicaid expansion offered new and vulnerable patients, who were previously uninsured increased access to prescription drugs.").

182. *See id.* at 360. The authors of the study explained their inferences with the following:

> Similar to our analysis, previous studies and reports have estimated that Medicaid prescription expenditures increased by 24.3% in the whole population, 24.6% among expansion states, and 14.1% in nonexpansion states between 2013 and 2014. Furthermore, it has been estimated that expansion states and nonexpansion states increased the number of Medicaid prescriptions by 25.4% and 2.8%, respectively. This study adds to this growing body of literature by examining the effect of Medicaid expansion on prescription drug use and reimbursement trends over time.

Id.

183. *See* MEDICAID FINANCING: THE BASICS, *supra* note 6, at 8. The Kaiser Family Foundation has predicted that results, such as those from the study under discussion, would occur, explaining:

> Medicaid spending flows through a state's economy and can generate impacts greater than the original spending alone. The infusion of federal dollars into the state's economy results in a multiplier effect, directly affecting not only the providers who received Medicaid payments for the services they provide to beneficiaries, but indirectly affecting other businesses and industries as well. More recent analyses find positive effects of the Medicaid expansion on multiple economic outcomes, despite Medicaid enrollment growth initially exceeding projections in many states. Studies show that states expanding Medicaid under the ACA have realized budget savings, revenue gains, and overall economic growth.

Id.

184. *See* Tal Gross & Matthew J. Notowidigdo, *Health Insurance and the Consumer Bankruptcy Decision: Evidence from Expansions of Medicaid*, 95 J. PUB. ECON. 767, 776 (2011).

significant interaction between these two types of insurance: a 10 percentage point increase in Medicaid eligibility would decrease bankruptcies by about 8%."[185] Even more, after recognizing that "Medicaid expansion appears to lead to greater transfers from debtors to creditors," the study suggested that economic effects of fewer bankruptcies might induce lenders to lower prices to other borrowers.[186]

Expanding Medicaid coverage has been found to improve the overall financial health in low-income families.[187] A study found that making one additional family member Medicaid eligible reduced family "medical spending by 2.7 percentage points" per quarter.[188] Furthermore, this study found that even with the effects of "crowd-out"—where Medicaid expansion crowds out private coverage—expansion still led to decreased medical spending and overall welfare improvements.[189]

Expanding Medicaid coverage may also provide savings for the federal Supplemental Security Income (SSI) program.[190] Providing financial assistance for poor adults with disabilities inhibiting their ability to work, SSI qualification usually guarantees Medicaid eligibility.[191] Analyzing the twelve states that introduced Medicaid coverage for childless adults between 2001 and 2013,[192] researchers

185. *Id.* ("A 10 percentage point increase in Medicaid eligibility is itself an enormous expansion of social insurance. But in the 1990s, bankruptcies increased by roughly 5% each year. Out results therefore suggest that a massive expansion of Medicaid would prevent about one year of 1990's-era growth in consumer bankruptcies.").

186. *Id.* at 777.

187. *See* Marcus Dillender, *Medicaid, Family Spending, and the Financial Implications of Crowd-out*, 53 J. HEALTH ECON. 1 (2016).

188. *Id.* at 13 ("Although much of this decrease appears to come from families who had small medical expenditures, I cannot rule out meaningful decreases in large expenditure risks.").

189. *See id.* at 14 ("In short, Medicaid realizes its intended effect of reducing medical expenditures for low-income families, but focusing solely on Medicaid's effect on medical expenditures ignores a major part of Medicaid's contribution to low-income families' financial health.").

190. *See* Marguerite Burns & Laura Dague, *The Effect of Expanding Medicaid Eligibility on Supplemental Security Income Program Participation*, 149 J. PUB. ECON. 20 (2017).

191. *See id.* at 20 ("Historically, participation in the SSI program has served as the primary route to Medicaid coverage for adults with disabilities.").

192. *See id.* at 23 ("These include the following: ten states that introduced and maintained Medicaid coverage for childless adults, CA, CO, CT, IN, IA, ME, MD, MI, UT, WI; one state that introduced and discontinued childless adult coverage, PA; and one state

found that this Medicaid expansion led to a reduction in SSI participation of 5%–7%.[193] Consequently, using the 5%–7% figure, this same study estimates that "a reduction of this size translates into a reduction in beneficiaries of 31,600 to 44,280 and a decrease of $6.6 to $9.3 million in federal SSI payments for each enrollment month within the 12 affected states."[194]

Interestingly, expanding Medicaid has also been shown to reduce crime rates.[195] One study examining the crime-reduction effect of state Medicaid expansions under the Health Insurance Flexibility and Accountability (HIFA) waivers found that a 10% increase in substance use disorder (SUD) treatments could "reduce the rate of robbery by 3%, reduce the rate of aggravated assault by 6 to 7%, and reduce the rate of larceny theft by 3%."[196] Understanding that crimes have economic costs,[197] after listing the annual costs of such crimes,[198] this study calculated that a 10% increase of the $16 billion dollars (2007) spent on SUD treatments at a cost of "$1.6 billion can yield an average benefit of $2.9 billion

the discontinued Medicaid coverage for childless adults that had been introduced before 2001, TN.").

193. *See id*. at 31.

194. *Id*. ("While these dollar amounts may be imprecise, this stylized estimate conveys the magnitude of the program-level effects following the new Medicaid coverage for childless adults in the study states on SSI participation. Additionally, we may expect gains in efficiency to the extent that the higher income and asset thresholds for Medicaid expansion (relative to SSI) reduce labor supply distortions. This study's findings signal the importance of evaluating the cross-program effects of the ACA expansions to capture the full implications of increased Medicaid availability on public welfare spending and labor force participation among low-income adults.").

195. *See* Hefei Wen et al., *The Effect of Medicaid Expansion on Crime Reduction: Evidence from HIFA-Waiver Expansions*, 154 J. PUB. ECON. 67, 67 (2017); *see also* Susan L. Ettner et al., *Benefit-Cost in the California Treatment Outcome Project: Does Substance Abuse Treatment "Pay for Itself"?*, 41 HEALTH SERVS. RES. 192, 205–06 ("Our best estimate is that on average, substance abuse treatment costs $1,583 and is associated with a societal benefit of $11,487, representing a 7:1 ratio of benefits to costs (9:1 when arrest data are 'inflated' to proxy for actual crimes committed).").

196. *The Effect of Medicaid Expansion on Crime Reduction*, *supra* note 195, at 79.

197. *See id*. ("These estimated costs of crime attempt to capture the direct tangible losses to crime victims and to the criminal justice system, the opportunity costs associated with the criminal's choice to engage in illegal rather than legal activities, as well as indirect and intangible losses suffered by crime victims, including pain and suffering, decreased quality of life, and psychological distress.").

198. *See id*. ("[T]he annual costs are roughly $15 billion to $19 billion for robbery, $8 to $25 billion for aggravated assault, and $65 billion to $92 billion for larceny theft (2008 dollars).").

to $5.1 billion from reducing crime rates."[199] Echoing this study's conclusion, expanding Medicaid to provide earlier treatments "is an effective policy lever to encourage treatment use and reduce substance use, which in turn, can cost-effectively reduce crimes."[200]

Expanding coverage with a preventative approach will certainly necessitate upfront spending. But taxpayers will foot the bill either way. For example, in 2013—the last year before the ACA went into effect, and possibly indicative of the costs with a Medicaid block grant—the federal government paid $32.8 billion (61.5%) of the year's total uncompensated care, with states and other localities contributing $19.8 billion (37.1%) themselves.[201]

Alarmingly, despite these enormous amounts paid in uncompensated care, studies suggest that hospitals still absorb between 60% and 67% of the costs of their uncompensated care,[202] putting many at risk of closure.[203] Hospitals are not well situated to pass that cost on to insured consumers either,[204] putting those that serve more uninsured patients at a greater risk for closure compared to other hospitals.[205] These consequences are likely not

199. *Id.*

200. *See id.*

201. *See* THE KAISER COMM'N ON MEDICAID & THE UNINSURED, KAISER FAM. FOUND., UNCOMPENSATED CARE FOR THE UNINSURED IN 2013 14 (2014), https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8596-uncompensated-care-for-the-uninsured-in-2013.pdf.

202. *See* Craig Garthwaite et al., *Hospitals as Insurers of Last Resort* 38 (Nat'l Bureau of Econ. Research, Working Paper No. 21290, 2015), http://www.nber.org/papers/w21290.pdf.

203. *See id.*

204. *See id.* at 36. The authors of the study explain how it is difficult for hospitals to shift the costs of the uninsured to others, suggesting:

> The attractiveness of cost-shifting arguments to policymakers is obvious. However, there is not strong theoretical or empirical support for this argument. Theoretically, it is unclear how hospitals could raise prices on one group of patients following a lump-sum financial shock from another group. If hospitals were maximizing profits, then prices should have been optimal before the shock. For a price increase to be the optimal response to a financial shock requires two conditions. First, the hospital must possess some degree of pricing power in the private insurance market. Second, the hospital must not have fully exercised this power prior to the shock.

Id.

205. *See id.* at 40. The researchers in the study made the following conclusions regarding uncompensated care and hospital closures:

> Similarly, [other researchers] found that from 1990 to 2009, approximately 30 percent of the nation's EDs closed, primarily due to hospital closures. ED closures were more likely to occur in low-income areas and at hospitals with low profit margins. Our results indicate that an ED attracts a large amount of

limited to just hospitals, as it can be deduced that near 40% of uncompensated care is provided by an entity other than a hospital, which is likely to also be absorbing a significant portion of uncompensated-care costs.[206]

"Medicaid is a lean program."[207] Due to lower payments to providers and lower administrative costs it is less expensive to insure someone on Medicaid than private insurance.[208] In fact, over the period from 2007 to 2013, the increase in per-enrollee spending in the Medicaid program was 3.1%, which was less than private insurance pre-enrollee premiums.[209] With Medicaid being the most cost-effective coverage available, instead of block granting Medicaid, serious consideration ought to be given to expanding Medicaid to cover more treatments and insure more people.

These surveys provide evidence of expanded Medicaid coverage encouraging effective, long-term planning, the streamlining of inefficient or duplicative programs, and the limiting of uncontrollable spending. Therefore, this snapshot of the available research conducted on the effects of expanding Medicaid provides support for the fact that conservative Medicaid goals are still obtainable under an expanded Medicaid program focused on an early intervention model of Medicaid funding.

3. Access to care correlates with increased preventive care

It may appear as if these two different approaches to Medicaid would have the same economic impact on the state level. After all, a necessary objective of any successful approach must be to curb unsustainable spending. And one could argue that the expansion of coverage with a focus on preventive care merely redirects the large sums of money currently spent on hospital care for the

> uncompensated care to a hospital, with sharp increases in uncompensated care when nearby hospitals close. This may explain why areas with low rates of health insurance have seen so many ED closures in recent years.

Id.

206. *See id.* at 38.

207. INTRODUCTION TO MEDICAID, *supra* note 6, at 4 ("And over the past decade, costs per beneficiary grew much more slowly for Medicaid than for employer-sponsored insurance. The . . . Centers for Medicare and Medicaid Services projects that Medicaid spending per beneficiary will grow no more rapidly through 2025 than spending per beneficiary with private insurance.").

208. *See id.*

209. *See* MEDICAID FINANCING: THE BASICS, *supra* note 6, at 4.

chronically ill to another part of the healthcare industry where the focus is on early treatment. The expenses that were attributable to hospital care would simply be shifted elsewhere on preventive care for more individuals—with total expenses remaining unchanged. But that is not the case. Aside from the economic gains that may come from the examples mentioned above, the real gains from expanding Medicaid will be seen in the quality of life gains available for beneficiaries through their utilization of their access to Medicaid.

The most important reason why expanding Medicaid coverage is the better of the two policies is that it will provide more access to care which may lead to improved health-related behaviors and outcomes.[210] A study that compared two Medicaid expansion states (Kentucky and Arkansas) with one non-expansion state (Texas) found a 14.0% one year decrease and a 22.7% two year decrease in the uninsured rate as compared to the baseline year.[211] This access to care resulted in a 12.1% increase of beneficiaries having a personal physician, a 6.1% decrease in reliance on ER care, a 18.2% reduction in cost-related barriers to care, a 11.6% decrease in prescription medication skipping, and a 29.5% reduction in out-of-pocket medical spending.[212] Compared to Texas, Medicaid expansion was also found to have resulted in a 16.1% increase in medical checkups, a 6.3% increase in a glucose check, a 10.7% increase in glucose monitoring, and a 12% increase in chronic condition care.[213]

210. *See* Benjamin D. Sommers et al., *Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance*, 176 J. AM. MED. ASS'N INTERNAL MED. 1501, 1507–08 (2016) ("After 2 years of coverage expansion in Kentucky and Arkansas, compared with Texas's nonexpansion, there were major improvements in access to primary care and medications, affordability of care, utilization of preventive services, care for chronic conditions, and self-reported quality of care and health."); *see also* Amy Finkelstein et al., *The Oregon Health Insurance Experiment: Evidence from the First Year* 23 (Nat'l Bureau of Econ. Research, Working Paper No. 17190, 2011), https://www.nber.org/papers/w17190.pdf (finding that insurance coverage correlated with preventive care, including a "20 percent increase in the probability of ever having one's blood cholesterol checked, a 15 percent increase in the probability of ever having one's blood tested for high blood sugar or diabetes, a 60 percent increase in the probability of having a mammogram within the last year (for women 40 and over), and a 45 percent change in the probability of having a pap test within the last year (for women)").

211. *See* Sommers, *supra* note 210, at 1503.

212. *See id.*

213. *See id.*

Another study found that the "Medicaid expansion significantly increased the probability of receiving an HIV test in the past year by 2.3 percentage points" and "a 4.1 percentage point increase . . . in the probability of a dental visit."[214] Similar studies have found beneficiary usage of their expanded Medicaid coverage led to a "significant increase in rates of diagnosis of chronic health conditions" as well as "increases in respondent reports of . . . being diagnosed with diabetes and high cholesterol."[215]

This early evidence that increased Medicaid access has correlated with an increase in preventive care is in its infancy. Hopefully these early results will provide the necessary synergy to expand Medicaid access to benefit the lives of more people, which is a principle that both conservatives and liberals can agree on.

III. CONCLUSION

Despite the "sharp partisan disagreement" over its future, Medicaid appears durable.[216] Medicaid's durability is evidenced by the fact that Medicaid has changed significantly from its inception in 1965—beginning as almost an afterthought—to now becoming the program, according to some, capable of transitioning the United States to universal coverage.[217] Despite the continuing challenges of Medicaid, according to Professor Michael S. Sparer, professor of

214. Kosali Simon et al., *The Impact of Health Insurance on Preventive Care and Health Behaviors: Evidence from the First Two Years of the ACA Medicaid Expansions*, 36 J. POL'Y ANALYSIS & MGMT. 390, 404 (2017).

215. Laura R. Wherry & Sarah Miller, Early Coverage, Access, Utilization, and Health Effects of the Affordable Care Act Medicaid Expansions: A Quasi-Experimental Study 7 (June 21, 2016) (author manuscript), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5021068/pdf/nihms807579.pdf.

216. *See* Drew Altman & William H. Frist, *Medicare and Medicaid at 50 years: Perspectives of Beneficiaries, Health Care Professionals and Institutions, and Policy Makers*, 314 J. AM. MED. ASS'N 384, 386–87 (2015). The study's authors stated:

> Medicare and Medicaid are quite different today than 50 years ago, a potentially important lesson for the current debate over the ACA. . . . Medicaid has changed over the years to expand eligibility to cover more low-income Americans, provide coverage for 1 in 3 of the nation's children, fill gaps in Medicare coverage for elderly and disabled people, facilitate development of long-term care services and supports in the community, and introduce delivery system reforms.

Id. at 387.

217. *See* Sparer, *supra* note 1, at 1090.

health policy and management at Columbia University,[218] Medicaid's outlook appears promising:

> Although it is not inevitable, Medicaid is most likely going to continue its remarkable growth. The interest-group support is not likely to fade, even if conservative politicians and underpaid office-based physicians remain opposed. Similarly, the US Supreme Court decision converting the ACA mandate into a state-controlled option may provide an unexpected and unintended political benefit, minimizing complaints of a monolithic national program and strengthening the program's political support. Medicaid's intergovernmental financing structure also will continue to encourage expansion; the federalist catalyst here is unlikely to disappear. Finally, politics aside, state Medicaid programs are now using their massive purchasing power to redesign the health care delivery system. Here again, the program's federalist structure encourages innovations that are likely to meet the needs of diverse local markets.[219]

If Professor Sparer's predictions hold true—and history suggests they might—then the expanded Medicaid coverage that occurs will ensure that states retain their flexibility to implement their Medicaid programs as they desire. This expansion will simultaneously promote fiscal prudence and protect more potential beneficiaries by, among other things, allowing them access to early, preventive treatments for diseases.

Brent Miller[*]

218. *See id.* at 1084.

219. *Id.* at 1090–91.

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