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Medicaid's Next Fifty Years: Aligning an Old Program with the New Normal

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MEDICAID'S NEXT FIFTY YEARS: ALIGNING AN OLD PROGRAM WITH THE NEW NORMAL

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I. INTRODUCTION

The largest of all means-tested entitlement programs and a long-term survivor of battles over spending and ideology, Medicaid was significantly transformed by the Patient Protection and Affordable Care Act (ACA).[1] But further reforms are needed if Medicaid is to emerge as what Chief Justice John Roberts in *NFIB v. Sebelius* characterized as "an element of a comprehensive national plan to provide universal health insurance coverage."[2] Medicaid figured prominently in the Court's decision; the ruling, which barred the Secretary from fully enforcing the terms of the mandatory expansion,[3] can be expected to have a significant impact on the rate and scope of state implementation of the Medicaid reforms. Even so, most observers expect states ultimately to implement the expansion, reasoning that the enormous need for insurance coverage for the poor, coupled with the Act's financial advantages, will lead states to move forward.[4] As they do, one would expect that the wheels of legislative

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1. *See, e.g.*, I.R.C. §§ 36B(b)(3)(A)(i), (b)(2) (2011); Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 2001, 1413, 124 Stat. 119, 233, 271 (codified at 42 U.S.C. §§ 18083, 1396a(e) (2011)) [hereinafter ACA].

2. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2606 (2012) [hereinafter *NFIB*].

3. For a comprehensive discussion of the ruling, see Nicole Huberfield et al., *Plunging Into Endless Difficulties: Medicaid and Coercion in the Healthcare Cases* (B.U. Sch. of Law, Working Paper No. 12-40, 2012), *available at* http://www.bu.edu/law/faculty/scholarship/workingpapers/2012.html; *see also* Samuel Bagenstos, *The Anti-Leveraging Principle and the Spending Clause After NFIB* (Geo. L.J. Research Paper No. 286, 2012), *available at* http://ssrn.com/abstract=2128977.

4. By mid-February 2013, officials in 18 states had indicated that they were definitely not participating or leaning in that direction. The remaining states were either in the process of adoption, leaning toward adoption, or undecided. *Where States Stand on the Medicaid Expansion*, THE ADVISORY BOARD (Feb. 15, 2013), http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap#lightbox/1/. Indeed, several Republican governors who

innovation would continue to turn, as they have for decades, in order to produce the next generation of legislative amendments essential to retrofitting an established program to a new order. But the question that now confronts Medicaid is whether the reform process will be business as usual or whether a poisonous political environment will impede this effort to assure that Medicaid indeed is able to more successfully play an expanded role in the American health system.

Continuing the work of re-designing Medicaid is essential for two reasons. First, the success of the ACA's insurance reforms hinges on the new system's ability to enroll millions of previously uninsured young, healthy working-age adults and their families. Today this population is strikingly poor: more than one-third of all Americans live in families with incomes below twice the federal poverty level,[5] and it is this group that lacks health insurance coverage.[6] Thus, a large proportion of the newly insured will require subsidies if coverage is to be affordable. Because Congress chose to design a subsidy coverage system that spans two distinct markets (Medicaid and state health insurance Exchanges),[7] assuring their harmonious functioning becomes central to the success of health reform. This aim assumes special importance for younger, healthier people, whose tolerance for frequent coverage lapses and loss of access to network physicians may be minimal.

Second, additional reforms are needed in order to align Medicaid's new mission to insure virtually all poor U.S. residents[8] with other program

initially had strongly opposed the Medicaid expansion were moving toward its embrace. Paul West, *Medicaid Expansion Divides GOP Governors*, L.A. TIMES (Feb. 7, 2013), http://articles.latimes.com/2013/feb/07/nation/la-na-medicaid-20130208/2.

5. CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2011, at 18 tbl.5 (2012), *available at* http://www.census.gov/prod/2012pubs/p60-243.pdf.

6. In 2011, more than three-quarters of uninsured Americans had family incomes below 250% of the federal poverty level. KAISER FAMILY FOUND., THE UNINSURED AND THE DIFFERENCE HEALTH INSURANCE MAKES 2 fig.3 (2012), *available at* http://www.kff.org/uninsured/upload/1420-14.pdf.

7. KAISER FAMILY FOUND., EXPLAINING HEALTH REFORM: ELIGIBILITY AND ENROLLMENT PROCESSES FOR MEDICAID, CHIP, AND SUBSIDIES IN THE EXCHANGES 1 (2010), *available at* http://www.kff.org/healthreform/upload/8090.pdf.

8. Medicaid excludes coverage of otherwise eligible persons not lawfully present in the United States. Medicaid eligibility for non-citizens is linked to their immigration status, and the law imposes a five-year waiting period on eligibility for legal U.S. residents. *See* ALLISON SISKIN, CONG. RESEARCH SERV., TREATMENT OF NONCITIZENS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 7 (2011), *available at* http://www.nafsa.org/uploadedFiles/CRS%20analysis%20re%20noncitizens.pdf. Legal residents are covered by the Act's minimum coverage requirements and entitled to use state Exchanges. They may obtain subsidized coverage through health insurance Exchanges as well as tax subsidies during their five-year waiting period for Medicaid coverage. Persons not lawfully present in the U.S. are excluded

responsibilities. The first responsibility is to finance healthcare for millions of children and adults with disabilities, for whom conventional health insurance (even if they have it) is not sufficient. The ACA bars pre-existing condition exclusions[9] and annual and lifetime dollar limits on most covered care;[10] the law also imposes annual limits on families' out-of-pocket cost exposure.[11] But these reforms offer inadequate protection for conditions that require treatments that lie beyond the outer limits of the commercial insurance coverage design that is the ACA's hallmark in the new insurance market. Historically, Medicaid has played the dominant role in long-term care, not only as a primary insurer, but also as a supplemental insurer for individuals with primary coverage through Medicare or employer-sponsored plans.[12] Aligning Medicaid's historic role in financing care for people with disabilities represents a major challenge left shockingly unaddressed by the ACA, with potentially dangerous results.

The second responsibility is support for the healthcare safety net; indeed, Medicaid has long served as the economic base on which the safety net rests.[13] The safety net is complex, comprised of healthcare institutions with a

from the minimum coverage requirement, I.R.C. § 5000A(d)(3) (2011), and also are excluded from purchasing health insurance coverage through state Exchanges. ACA § 1312(f)(3) (codified at 42 U.S.C. § 18032 (2011)). Of the nation's 21.6 million non-citizens, approximately 11.2 million are estimated to be not lawfully present. SISKIN, *supra,* at 2-3. Compared to the general population, undocumented persons are far more likely to be uninsured (47% compared to 15%). KAISER FAMILY FOUND., SUMMARY: FIVE BASIC FACTS ON IMMIGRANTS AND THEIR HEALTH CARE (2008), *available at* http://www.kff.org/medicaid/upload/7761.pdf.

9. ACA § 1201 (codified at 42 U.S.C. § 300gg-3 (2011)).

10. ACA § 1001 (codified at 42 U.S.C. § 300gg-11 (2011)). The bar on annual and lifetime dollar limits applies only to benefits and services falling within the Act's essential health benefit categories. *Id.* § 1302 (codified at 42 U.S.C. § 18022 (2011)).

11. ACA § 1201 (codified at 42 U.S.C. § 300gg-1 (2011)).

12. KAISER COMM'N ON MEDICAID FACTS, MEDICAID AND LONG-TERM CARE SERVICES AND SUPPORTS 1 (2009), *available at* http://www.kff.org/medicaid/upload/2186_06.pdf; KAISER FAMILY FOUND., MEDICARE CHARTBOOK, SECTION SIX: SUPPLEMENTAL INSURANCE COVERAGE 58 (4th ed. 2010).

13. Medicaid accounts for 35% of public hospitals' net revenue and 37% of health center funding. *See* NAT'L ASS'N OF PUBLIC HOSPITALS AND HEALTH SYSTEMS, IN UNCERTAIN TIMES, SAFETY NET HOSPITALS MAINTAIN COMMITMENT TO SERVE 2 fig.2 (2012), *available at* http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/FY2010- Characteristics-Report-Summary.aspx?FT=.pdf; *see generally* PETER SHIN ET AL., KAISER FAMILIY FOUND., HEALTH CENTERS: AN OVERVIEW AND ANALYSIS OF THEIR EXPERIENCES WITH PRIVATE HEALTH INSURANCE (2008), *available at* http://www.kff.org/uninsured/upload/7738.pdf; SHIN ET AL., GEO. WASH. U. SCH. PUB. HEALTH & HEALTH SERVS., AN INITIAL ASSESSMENT OF THE EFFECTS OF MEDICAID DOCUMENTATION REQUIREMENTS ON HEALTH CENTERS AND THEIR PATIENTS 6 (2007), *available at* http://sphhs.gwu.edu/departments/healthpolicy/CHPR/downloads/Medicaid_Doc_Requirements.pdf.

tradition of serving poor and vulnerable patients, as well as entities such as public hospitals and federally funded community health centers[14] that by law must furnish care to all residents of their service areas[15] and that are protected under Medicaid through special payment rules.[16]

The safety net's role will likely only intensify in the wake of reform.[17] Even at full implementation, 27 million people will remain uninsured,[18] and the remaining uninsured can be expected increasingly to shift into safety net settings.[19] Furthermore, persons newly insured under Medicaid will be more likely to reside in medically underserved communities characterized by elevated poverty and health risks and reduced access to care, because of the strong association between low income and lack of health insurance.[20] Additionally, millions of lower income safety net patients who gain coverage will nonetheless continue to face significant cost-sharing obligations both for covered benefits (subsidized health insurance plans sold through Exchanges will have only a 70% actuarial value,[21] and cost sharing reduction assistance is available but by no means complete) and for uncovered costs such as adult dental care. The safety net can be expected to absorb the immediate surge in healthcare use following full implementation.

14. For a general discussion of community health centers and the Affordable Care Act, see Eli Adashi et al., *Health Care Reform and Primary Care – The Growing Importance of the Community Health Center*, 362 NEW ENG. J. MED. 2047 (2010).

15. For a general discussion of the healthcare safety net, see INST. OF MED., THE HEALTH CARE SAFETY NET: INTACT BUT ENDANGERED (2000). For a discussion of how the ACA affects safety net institutions and providers, see Mark Hall & Sara Rosenbaum, *The Health Care Safety Net in the Context of National Health Insurance Reform, in* THE HEALTH CARE SAFETY NET IN A POST-REFORM WORLD (Mark Hall & Sara Rosenbaum eds., 2012) [hereinafter SAFETY NET].

16. Rosenbaum, *Reinventing a Classic: Community Health Centers and the Newly Insured*, *in* SAFETY NET, *supra* note 15, at 76-77.

17. *Id.* at 76.

18. CONG. BUDGET OFFICE AND JOINT COMM. ON TAXATION, UPDATED ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT 12 tbl.3 (2012), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf.

19. This is precisely what happened in Massachusetts in the wake of that state's health reform effort; following passage, health centers served an even higher proportion of the state's remaining uninsured population. Leighton Ku et al., *Safety Net Providers After Health Reform: Lessons from Massachusetts*, 171 ARCHIVES OF INTERNAL MED. 1379, 1382-83 (2011).

20. ROSENBAUM ET AL., GEO. WASH. U. SCH. PUB. HEALTH & HEALTH SERVS., NATIONAL HEALTH REFORM: HOW WILL MEDICALLY UNDERSERVED COMMUNITIES FARE? 10-11 (2009), *available at* http://sphhs.gwu.edu/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_5046C2DE-5056-9D20-3D2A570F2CF3F8B0.pdf.

21. The silver plan, the standard health plan linked to premium tax credits in health insurance Exchanges, is pegged to 70% of the full actuarial value of benefit. ACA § 1302(d)(1)(B) (codified at 42 U.S.C. § 18022 (2011)); *id.* § 1401 (codified at I.R.C. § 36 (2011)).

A third responsibility is improving health care for the poor. Continuity is a holy grail of healthcare quality improvement, one on which deeper health system improvements largely depend. Now that Congress has chosen to create two separate markets for subsidized coverage, the task becomes market alignment in ways that enable more stable coverage, foster longer term relationships between patients and providers, and reduce the potential for gaming in a system that, driven by market forces, may be incentivized to skimp on care, secure in the knowledge that in a matter of months, patients will disappear. Medicaid offers rich and extensive coverage. It is unique in that respect and has proved capable of achieving important health and healthcare outcomes for the poor.[22] Now the goal is its greater integration in to a broader, subsidized market for health care.

The article examines Medicaid in the wake of the ACA and prospects for further reform given the political environment that now envelopes it.

II. THE ACA AND MEDICAID'S FIVE ALIGNMENT CHALLENGES

A. Context

Uninsured people are the chief immediate beneficiaries of the sweeping reforms made by the ACA. But being uninsured is not a static event, and even before passage of the Act, churning in and out of coverage was a well-documented problem,[23] with over 40% of Medicaid-insured adults losing coverage within a year.[24] The problem of coverage churn will persist in the wake of the ACA; its potential magnitude was captured in a 2011 study[25] that simulated the coverage experience of adults with incomes below twice the federal poverty level at the point of full implementation of the Affordable Care Act. The study found that within 6 months, over 35% of American adults with incomes below twice the federal poverty level can be expected to experience a change in income that will shift them from Medicaid (where eligibility ends at 133% of the federal poverty level) to coverage through a

22. Many studies have shown Medicaid's impact on the health of the poor. *See, e.g.*, KAREN DAVIS & CATHY SCHOEN, HEALTH AND THE WAR ON POVERTY: A TEN-YEAR APPRAISAL (The Brookings Inst. ed., 1978) (discussing the reduction in infant mortality and benefits to the poor credited to Medicaid); Benjamin D. Sommers et al., *Mortality and Access to Care Among Adults After State Medicaid Expansions*, 367 NEW ENG. J. MED 1025 (2012) (showing that Medicaid has been shown to achieve important health outcomes for its beneficiaries).

23. *See, e.g.*, Pam Farley Short & Deborah R. Graefe, *Battery-Powered Health Insurance? Stability in Coverage of the Uninsured*, HEALTH AFF., Nov.–Dec. 2003, at 244.

24. Benjamin D. Sommers, *Loss of Health Insurance Among Non-elderly Adults in Medicaid*, 24 J. GEN. INTERNAL MED. 1, 2 (2009).

25. Benjamin D. Sommers & Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*, 30 HEALTH AFF. 228, 232 (2011).

state health insurance Exchange, or the reverse. Within one year, 50% — 28 million adults — will experience a shift in one direction or the other. Even more striking, 24% of this group will have experienced 2 or more changes in one year; over a two-year period, the number experiencing two or more changes rises to 39%. More than 40% of these adults are estimated to have children under age 19, meaning that the problem will affect both millions of children and adults.

The adverse ramifications of churn are great, not only for the families that experience the effects of churn — interrupted coverage, plan switching between two markets, and breaks in the continuity of treatment from a regular provider — but also for the broader goal of affordability. The estimated 56 million low income adults and 35 million children who will experience post-reform churn across the Medicaid and Exchange markets[26] represent the healthiest risk groups across the two markets. Unlike the millions of older and sicker adults who gain enormous benefits from health reform, this group is in the workforce and in relatively good health. The cause of their cross-market churn is, of course, income fluctuation, which is more likely to occur in working families than in adults who are in poorer health and living on fixed incomes.[27] For these families, income fluctuates as younger workers enter and leave the job market, add or drop hours of employment, or have children, thereby increasing family size in relation to total household income, which in turn triggers an effective decline in family income in relation to the federal poverty level.

B. Specific Challenges

Addressing the problem of constant churning across two distinct insurance markets requires multiple types of market alignment. Entry into the system needs to be conceptualized as a single point of entry, where people can be linked to the proper subsidy source both initially and as circumstances change. Enrollment must be stable so that re-evaluation of financial eligibility for subsidies need happen only periodically, in the manner of an annual enrollment period. Benefits and cost sharing need to be aligned so that members become accustomed to what is and is not covered. The same health plans using the same delivery networks should be sold in the two markets so that in the event that the source of subsidy needs to change as a result of fluctuation in real or effective income, plan membership and provider continuity will remain stable. Under this scenario, fluctuating income would entail a transactional shift in subsidy source, but no shift in coverage or care.

26. *Id.* at 232.
27. *Id.* at 229.

The question is whether the Medicaid reforms introduced under the Act are sufficient to get the system to this point, even assuming that states fully implement the Medicaid expansion in the wake of *NFIB* and that states implement choices that are consistent with this vision of market alignment. Unfortunately, the ACA Medicaid amendments fall short in a number of key respects, as do the provisions establishing state Exchanges. Furthermore, early implementation of the Act by the United States Department of Health and Human Services (HHS) suggests a willingness to tolerate state implementation choices that are at odds with market alignment. Finally, the Act entirely fails to recognize a crucial issue related to Medicaid's longstanding role as a source of supplemental health insurance for children and adults with disabilities.

1. Aligning Enrollment

The ACA creates two distinct subsidized health insurance markets: Medicaid for the poorest people; and premium subsidies and cost sharing reduction assistance offered through state Exchanges for persons whose incomes fall below the upper limits for this type of affordability assistance,[28] but are too high to qualify for Medicaid.[29] Eligibility for premium subsidies is linked to coverage months,[30] and assistance is barred for any month that an individual is eligible for another form of "minimum essential coverage,"[31] which includes Medicaid.[32] The extraordinary degree to which, in an effort to avert a "crowd-out" effect,[33] Exchange premium subsidies must be exclusively focused on those without another form of coverage means that in a fluctuating income environment, enrollment and income evaluation functions between state Exchanges and Medicaid agencies must be exquisitely and continually aligned. To this end, the Act requires state Exchanges to screen all applicants for potential Medicaid eligibility and to "enroll such individuals in" Medicaid if their "modified adjusted gross

28. I.R.C. § 36B(b)(3)(A)(i) (2011). The range is from 133% of the federal poverty level to 400% of the federal poverty level.

29. *Id.* § 36.

30. *Id.* § 36B(b)(2).

31. *Id.* §§ 36B(b)(2), 36B(c)(2)(B), 5000A(f)(1)(C).

32. *Id.* § 5000A(f)(1)(A)(ii).

33. The extent to which concerns over government-supported health insurance "crowds out" private sector coverage has been a major, if misplaced, concern in U.S. health reform policy for decades. For an important critique, see Mark Schlesinger, *Crowding Out: Multiple Manifestations, Muddled Meanings*, 37 J. HEALTH POL. POL'Y & L. 851 (2012) (arguing that the concept has deterred government interventions aimed at correcting failures in the health insurance market).

income" (MAGI)[34] places them within the Medicaid eligibility range.[35] The Act further requires Medicaid agencies to undertake a series of steps aimed at simplifying the Medicaid enrollment and redetermination process itself[36] and to assure that individuals who apply for coverage through an Exchange and who are found eligible for Medicaid because their income is too low will be "enrolled" in Medicaid.[37]

Total alignment of enrollment functions certainly does not cure the problem of having to effectively re-evaluate income on a monthly basis. But it certainly helps. However, an already significant problem was worsened by an implementation choice made by the Centers for Medicare and Medicaid Services (CMS), which administers both the ACA's Medicaid and Exchange provisions. Despite the ACA's clarity on the issue of alignment through enrollment and re-enrollment, final CMS regulations permit Exchanges to stop at the point of eligibility determination and redetermination and simply transfer files to Medicaid agencies for final determinations and enrollment.[38] The abandonment of alignment through a unified enrollment process is the gift that will keep on giving, since, as the evidence shows, the process of losing and gaining income is a dynamic one that can take place multiple times throughout a given year. The absence of a single portal for enrollment, regardless of the source of premium subsidy, virtually ensures breaks in coverage, as the subsidy basis continually changes. This phenomenon is evident even in Massachusetts, where, years after reform, lower income adults continue to experience frequent breaks in coverage.[39]

Two changes might ease this problem. The first is requiring states to fulfill their system integration responsibilities by a set date and barring separate enrollment procedures. In states utilizing federally administered Exchanges (and the fact that only 13 states and the District of Columbia had enacted Exchange laws as of May 2012 suggests that many will do so),[40]

34. The Act establishes a "modified adjusted gross income" methodology for evaluating income for purposes of both Medicaid and Exchange affordability assistance. ACA § 2002 (amending 42 U.S.C. §1396a(e)(14) (2011)).

35. *Id.* § 1311(d)(4)(F) (codified at 42 U.S.C. § 18031 (2011)).

36. *Id.* § 1413 (codified at 42 U.S.C. § 18083 (2011)).

37. *Id.* § 1413(a).

38. 42 C.F.R. §§ 155.305(b), 155.310(d)(3) (2012).

39. John A. Graves and Katherine Schwartz, *Health Care Reform and the Dynamics of Insurance Coverage – Lessons from Massachusetts*, 367 NEW ENG. J. MED. 1181, 1183 (2012).

40. SARA ROSENBAUM ET AL., THE COMMONWEALTH FUND, STATE HEALTH INSURANCE EXCHANGE LAWS: THE FIRST GENERATION 1 (2012), *available at* http://www.commonwealthfund.org/Publications/Issue-Briefs/2012/Jul/State-Health-Insurance-Exchange-Laws/aspx.

such a change would require federal legislation, since by law, only a state Medicaid agency can determine eligibility for Medicaid.[41]

But even if greater alignment were to happen, either through state computerized integration of the Medicaid/premium subsidy enrollment function or through a federal law permitting federally administered Exchanges to directly enroll Medicaid-eligible persons in Medicaid,[42] the problem of income fluctuation as a result of a continual flow of life events means that the concept of measuring subsidy sources in relation to "coverage months" seems hopelessly inefficient. Informing government of changes in income, family size, and other matters that might affect eligibility will become an all-consuming event. Prior to the ACA, states had the flexibility to ignore minor income fluctuations[43] (although virtually none did so); in the wake of passage, however, this flexibility is eliminated in favor of a unified MAGI test, which eliminates states' power to disregard income fluctuations.[44]

Where cash welfare is concerned, there might be some limited justification for such a month-to-month approach to government assistance. Where the goal is to stabilize health care, the process is absurd on its face. Far more desirable would be legislation to establish annual enrollment periods with an uninterrupted entitlement to a subsidy source throughout the enrollment period. Obviously during periods in which the subsidy is tax-based, the federal government would absorb 100% of the costs, with states sharing the cost (after 2016 in the case of newly eligible persons and beginning in 2014 in the case of traditional eligibility groups, for whom the federal financial contribution remains at pre-ACA levels) in the case of Medicaid. Both the federal and state partners would want the other to bear as much cost exposure as possible. But life being what it is, over a several-year time period, the economics of annual enrollment periods would essentially be a wash.

2. Aligning Eligibility Policy for Persons with Disabilities

Medicaid plays two basic roles as an insurer. The first is as a primary insurer for millions of children and adults who have no other source of coverage, either through the employer system or any other insuring

41. 42 U.S.C. § 1396a(a)(5) (2011).

42. Whether a federal amendment commanding states to accept as eligible individuals determined eligible for Medicaid by a federal exchange could succeed politically is another matter.

43. *See, e.g.*, 42 U.S.C. § 1396a(a)(17) (2011) (requiring states to set reasonable standards for determining income); 42 C.F.R. § 435.916 (2012) (permitting states to establish annual eligibility periods).

44. ACA § 2002 (codified at 42 U.S.C. §1396a(e) (2011)).

mechanism. The second is as a supplemental insurer, both for Medicare beneficiaries[45] as well as for individuals who may have other forms of coverage, such as employer-sponsored benefits and for whom their primary coverage is inadequate. Medicaid's role as a secondary payer dates back to the program's 1965 enactment.[46] Indeed, the ACA strengthens Medicaid's potential role as a secondary payer by requiring states, as a condition of participation, to finance premium assistance as a part of Medicaid coverage, thereby potentially expanding Medicaid's role as a dual insurer.[47] In this respect, Medicaid's role as a supplemental source of coverage predates the policy shift toward exclusivity of coverage under governmental insurance programs, a shift that occurred in response to concerns over the claimed potential of public payers to "crowd-out" the private market.[48]

Medicaid's role as a supplemental insurer for persons with disabilities remains central to the program's role in the healthcare system, particularly in relation to the limitations of commercial insurance, whose design serves as the benchmark for the new subsidized Exchange market. Even though the ACA bars exclusion and discrimination on the basis of disability at the point of enrollment, the Act bakes discriminatory insurer practices into coverage design in several ways. The frame of reference for the essential health benefit (EHB) package[49] that lies at the heart of Exchange plans is the "typical" employer market.[50] Although the ACA bars the Secretary from introducing benefit designs in essential health benefits that discriminate on the basis of disability,[51] she has, in fact, ceded her authority over benefit design to states, who determine the design of their essential health benefit packages from among their employer-sponsored group markets.[52]

45. Approximately 9.1 million Medicare beneficiaries also were enrolled in Medicaid in FY 2008 for either partial or full coverage. KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID'S ROLE FOR DUAL ELIGIBLE BENEFICIARIES 1 (2012), *available at* http://www.kff.org/medicaid/upload/7846-03.pdf.

46. 42 U.S.C. §1396a(a)(25) (2011); *see also* COMM. ON WAYS AND MEANS, MEDICAID 1 (2003), *available at* http://waysandmeans.house.gov/media/pdf/greenbook2003/medicaid.pdf.

47. ACA § 2003 (codified at 42 U.S.C. § 1396e-1 (2011)).

48. *See* Schlesinger, *supra* note 33, at 854, 860.

49. ACA § 1302 (codified at 42 U.S.C. § 18022 (2011)).

50. *Id.* § 1302(b)(2)(A).

51. *Id.* § 1302(b)(4)(B). For a discussion of the non-discrimination in benefit design provision, see Sara Rosenbaum et al., *Crossing the Rubicon: The Impact of the Affordable Care Act on the Content of Insurance Coverage for Persons with Disabilities*, 25 NOTRE DAME J.L. ETHICS & PUB. POL'Y 527, 555 (2011).

52. CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, ESSENTIAL HEALTH BENEFITS BULLETIN 2, 8 (2011), *available at* http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

Other than extension of mental health parity to Exchange plans,[53] as of spring 2013, there is no final federal policy on how states must broadly adjust benefit design to counter discrimination in coverage on the basis of disability.[54] As a result, federal implementing standards do not override the limitations and exclusions commonly used to narrow coverage for persons with disabilities, such as medical necessity limitations that exclude coverage for which "normal" functioning cannot be restored, or exclusions that bar coverage for treatments considered "social" or "educational."[55] These types of limitations have no counterpart in Medicaid, which bars arbitrary limitations based on condition[56] and which provides uncommonly broad coverage of children under 21 through the early and periodic screening diagnosis and treatment benefit (EPSDT).[57]As such, Medicaid is particularly effective in coverage of supplemental long-term services and supports such as the services of personal attendants, additional levels of prescription drug coverage beyond that found in a typical employer plan, and additional treatments and services for conditions that require ongoing interventions. In other words, through its expansive coverage and third party liability provisions, Medicaid is designed to work alongside other forms of coverage. This has been particularly important for working families with disabled children, as well as for disabled adults who return to work and who, under expanded Medicaid eligibility policies, are permitted to retain Medicaid even while they have primary coverage through an employer.

However, rather than permitting Medicaid to play a supplemental role for persons with Exchange coverage, the ACA follows the exclusivity rule and introduces anti-crowd-out restrictions into the law by barring Exchange premium subsidies in any coverage month in which individuals are entitled to Medicaid coverage. This means that low and moderate income individuals and families entitled to Medicaid on the basis of disability are

53. ACA § 1311(j) (codified at 42 U.S.C. § 18031 (2011)).

54. Proposed regulations issued on November 26, 2012 and governing essential health benefits bar plan designs that discriminate on the basis of disability but offer no illustration of what such discrimination might look like. 77 Fed. Reg. 70644 (proposed Nov. 26, 2012) (to be codified at 45 C.F.R. §156.125).

55. *See, e.g.*, SARA ROSENBAUM, GEORGETOWN UNIVERSITY, O' NEILL INST., INSURANCE DISCRIMINATION ON THE BASIS OF HEALTH STATUS 6-7 (2009), *available at* http://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=1023&context=ois_papers (discussing types of exclusions which limit coverage for treatment); *see also* Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 U. KAN. L. REV. 73, 95 (2005) (discussing federal ADA interpretation which limits protection for persons with disabilities).

56. 42 C.F.R. § 440.230(c) (2012).

57. For a full discussion of the EPSDT benefit in relation to commercial insurance norms, see Sara Rosenbaum & Paul Wise, *Crossing the Medicaid-Private Insurance Divide: The Case of EPSDT*, 26 HEALTH AFF. 382 (2007).

ineligible to simultaneously receive premium subsidies for Exchange coverage. It also means that states are confronted with a basic choice: either continue higher Medicaid eligibility levels for children and adults with disabilities as permitted under law and forego the financial offsets that would accrue from their receipt of primary coverage through Exchanges; or eliminate more generous Medicaid eligibility standards for disabled children and adults in order to qualify them for fully federally funded Exchange subsidies. Furthermore, if, in response to the Medicaid expansion turmoil introduced into the picture by the Supreme Court's Medicaid holding in *NFIB*, the Administration were to permit states to partially implement the Act's Medicaid expansion provision — say, up to only 100% of the poverty line, which in turn triggers entitlement to Exchange premium subsidies under the ACA[58] — the termination point for Medicaid eligibility for persons with disabilities could sink even lower. An HHS ruling issued on December 10, 2012 in fact rejected a partial Medicaid expansion pathway as not authorized under the Act.[59] It appears therefore, that the potential for a rollback of disability-based Medicaid eligibility is limited to beneficiaries with family incomes exceeding the Exchange eligibility threshold.

One solution to this dilemma would require modification of both Medicaid and the ACA's premium assistance and Exchange provisions to permit states to continue to furnish Medicaid based on disability to low and moderate income persons whose simultaneous entitlement to medical assistance otherwise would be barred by the Act's anti-crowd-out provisions. In addition, amendments eliminating the anti-crowd-out provisions of the ACA in the case of disability would be paired with amendments that provide enhanced levels of federal funding to states that either retain or establish more generous Medicaid eligibility standards based on disability in order to supplement Exchange coverage.

It is too soon to tell, of course, what states will do. But the betting is on a massive Medicaid eligibility rollback of enhanced coverage based on disability in order to qualify persons with incomes above the Exchange threshold (wherever it might ultimately be set) for premium subsidies. In its current form, the Act simply provides no incentive for states to maintain higher Medicaid eligibility levels for persons with disabilities, nor does it

58. *See* Sara Rosenbaum & Timothy Westmoreland, *The Supreme Court's Surprising Decision On The Medicaid Expansion: How Will The Federal Government And States Proceed?*, 31 HEALTH AFF. 1663, 1668-69 (2012).

59. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., FREQUENTLY ASKED QUESTIONS ON EXCHANGES, MARKET REFORMS, AND MEDICAID 12 (Dec. 10, 2012), *available at* http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf; Sara Rosenbaum & Timothy Westmoreland, *The Administration's Decision on Partial Medicaid Implementation: True to the Law*, HEALTH AFF. BLOG (December 19, 2012), http://healthaffairs.org/blog/2012/12/19/the-administrations-decision-on-partial-medicaid-implementation-true-to-the-law/.

even allow states to do so. Indeed, the incentives appear to move state Medicaid policy in precisely the opposite direction, while denying persons with disabilities in more generous Medicaid states the ability to secure primary coverage through a qualified health plan offered through their state Exchange, a fundamental disability-based distinction if there ever were one.

3. Aligning Coverage Design

As noted, the ACA utilizes the EHB coverage design model for Exchange products. The ACA also grafts the EHB design onto the Medicaid coverage standards in the case of the newly eligible adult population.[60] Prior to the ACA's passage, states already had been given the option under the Deficit Reduction Act of 2005[61] to move to a more commercially-oriented "benchmark" benefit design in the case of certain low income adult and child populations. But the benchmark option excluded, among other beneficiary populations, parents receiving Temporary Aid to Needy Families (TANF) benefits and those who would have to continue to meet their states' 1996 Aid to Families with Dependent Children (AFDC) eligibility standards.[62] Thus, where the adult population was concerned, the 2006 benchmark option applied only to small groups of low income adults.[63]

The ACA replaces the 2006 benchmark coverage standard with the more rigorous EHB coverage design.[64] The ACA also preserves the state option to supplement commercial benchmark coverage with additional benefits, such as vision and dental care, that represent coverage options for adults.[65] Finally, the ACA retains the earlier benchmark coverage provision that requires states to supplement benchmark coverage in the case of individuals under age 21 with full Medicaid coverage for all EPSDT benefits.[66]

The ACA amendments create an anomalous situation. On the one hand, newly eligible low income adults receive EHB-level benchmark

60. ACA § 2001(c) (codified at 42 U.S.C. § 1396u-7(b) (2011)).

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

62. *See* 42 U.S.C. § 1396u-7(a)(2) (2011) (listing the excluded Medicaid beneficiary categories).

63. In effect, the only adults whose coverage could be subject to the benchmark standard would be certain narrow optional coverage groups such as 18-21 year olds who remained eligible for coverage under their state plan, optional pregnant women, and optional low income parents.

64. 42 U.S.C. § 1396u-7(b) (2011).

65. *Id.* § 1396u-7(a)(1)(C).

66. *Id.* § 1396u-7(a)(1)(A)(ii). For a discussion of the EPSDT benefit, which has a storied history and has been the subject of extensive litigation, see Rosenbaum & Wise, *supra* note 57.

coverage, including comprehensive preventive services without cost sharing, a wide array of other coverage classes, and full mental health parity. On the other hand, the poorest adult populations (those eligible for TANF or poor enough to still qualify for cash assistance under their state's 1996 AFDC program) receive traditional benefits that do not treat preventive care as a coverage requirement and that lack a mental health parity protection with the exception of beneficiaries enrolled in certain managed care arrangements.[67] Arguably the EHB benefit design actually is superior to Medicaid's traditional coverage design where low income adults are concerned, and yet the poorest adults are barred from receiving this level of coverage and remain consigned to Medicaid's traditional coverage design.

One solution would be to allow states to move all low income adults into the EHB benefit design. As previously discussed, such a move would result in certain limitations in coverage for low income adults that previously were barred under traditional Medicaid coverage rules, such as the prohibition against arbitrary discrimination on the basis of condition in the case of required services.[68] This prohibition, as noted, historically has prevented states from adopting certain commercial insurance practices, such as excluding certain conditions from coverage or denying treatments to patients whose conditions require treatments to avert further loss of functioning rather than restore "normal function." But, as also noted, this prohibition against arbitrary coverage rules is at least partially met through the mental health parity requirements that become applicable to EHB coverage arrangements under the ACA. Furthermore, because EHB design encompasses not only rehabilitative services but also those that are habilitative in nature, the EHB design limits the degree to which otherwise covered treatments can be excluded because they are prescribed in order to develop or maintain functioning rather than to restore the loss of prior function, a routine form of discrimination found in standard commercial plans.

Allowing states to move to the EHB design also would eliminate coverage requirements for certain services directly tied to support of the healthcare safety net, in particular, Medicaid's "federally qualified health center service" (FQHC) benefit,[69] which treats the services of community health centers as an actual coverage category, not simply a locus of care. At

67. *See* Letter from Cindy Mann, Dir. of Ctr. for Medicaid and State Operations, to State Health Officials 2 (Nov. 4, 2009), *available at* http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO110409.pdf (providing an explanation of how mental health parity affects managed care arrangements).

68. *See supra* notes 45-52 and accompanying text (regarding the interaction of Medicaid coverage standards and disability).

69. 42 U.S.C. § 1396d(a)(2)(C) (2011).

the same time, quite apart from the FQHC benefit mandate, federal Medicaid law also requires states to pay health centers at special enhanced rates for the covered benefits and services they furnish, thereby protecting them from a steep revenue loss for covered services. The FQHC payment rule, which is separate from the coverage rule, spans multiple healthcare delivery arrangements: qualified health plans sold in health insurance Exchanges;[70] Medicaid managed care arrangements;[71] health plans sold through the Children's Health Insurance Program;[72] and Medicaid's basic fee-for-service system.[73] Thus, even were the FQHC coverage requirement to be eliminated, Medicaid's special payment standard for covered benefits would remain in place, as would Medicaid's special payment rules for hospitals treating a disproportionate number of low income patients (DSH payments).[74]

4. Aligning Coverage Products

Federal Medicaid law provides for program administration, at state option, through managed care arrangements. Three-quarters of all

70. ACA § 10104 (codified at 42 U.S.C. § 18022 (2011)).

71. 42 U.S.C. §§ 1396u-7(b)(4), 1396u-2(h)(2)(C) (2011).

72. 42 U.S.C. § 1397gg(e)(1)(G) (2011).

73. 42 U.S.C. § 1396a(bb) (2011).

74. The fact that revising coverage rules under Medicaid would not alter safety net payment standards is only part of the story, however. The ACA imposes specific reductions on Medicare DSH hospital payments as well as states' Medicaid DSH allocations, which are fixed and subject to annual global limits as a result of amendments enacted to Medicaid in 1991 aimed at halting what was characterized as an abuse of the Medicaid DSH payment system. MEDICAID & CHIP PAYMENT AND ACCESS COMM. (MACPAC), MARCH 2012 REPORT TO CONGRESS ON MEDICAID AND CHIP 181 (2012), *available at* http://www.modernhealthcare.com/Assets/pdf/CH78650315.PDF. For a history of federal Medicaid DSH payment reforms, see *id.* at ch. 3. The ACA's DSH payment reductions were criticized prior to *NFIB* because of their overly optimistic assumption about the extent to which the Act's Medicaid eligibility expansions would reduce the need for supplemental funding for DSH hospitals; the ACA DSH amendments also were criticized for the degree to which the ACA continued to allow states latitude in how they target DSH payments. With the pace of the Medicaid expansion now thrown into uncertainty as a result of the Court's decision, the potential adverse implications of the ACA's DSH payment cuts looms larger. For an overview of the ACA DSH amendments, see *The Estimated Effect of the Affordable Care Act on Medicare and Medicaid Outlays and Total National Health Care Expenditures: Hearing before the H. Comm. on Energy & Commerce*, 112th Cong. (2011) (testimony of Richard Foster, FSA, Chief Actuary, Ctrs. for Medicare & Medicaid Servs.), *available at* http://www.hhs.gov/asl/testify/2011/03/t20110330e.html. For a discussion of the potential implications of the ACA DSH reductions on safety net hospitals without concomitant amendments to strengthen DSH targeting rules, see NAT'L ASS. OF PUB. HOSP. & HEALTH SYS., EQUITABLE, SUSTAINABLE, RELIABLE SAFETY NET FINANCING: MEDICAID DSH 3-4 (2012), *available at* http://www.modernhealthcare.com/Assets/pdf/CH78650315.PDF.

beneficiaries receive coverage through compulsory managed care enrollment,[75] akin to enrollment in a qualified health plan in a state Exchange. In both cases, the entities that sell these products (e.g., qualified health plans, Medicaid managed care products) must meet certain conditions of participation. The conditions vary, but not enormously. Indeed, the two sets of conditions of participation parallel one another across most areas, including marketing, access to care, network adequacy, grievance and appeals rights, access to emergency care, independent external review, and safety net payment requirements.[76]

There are differences in requirements, however, the most notable being an insurance licensure requirement that applies only to qualified health plans.[77] In addition, qualified health plans operating in state insurance exchanges must enter into agreements with certain "essential community providers."[78] No similarly comprehensive provider contracting provision applies to Medicaid managed care, but this is because, as a practical matter, Medicaid managed care networks already are dominated by "essential community providers" treating high volumes of low income patients.[79] Another difference between the Medicaid managed care market and the market for qualified health plans through the Exchanges involves accreditation: qualified health plans must be accredited,[80] whereas accreditation is not an express Medicaid managed care requirement. But even here, the differences are not insurmountable, as of 2010, 16 state

75. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID MANAGED CARE ENROLLMENT REPORT 1 (2011), *available at* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf.

76. *Compare* ACA § 1311 (codified at 42 U.S.C. § 18031 (2011)), *and* ACA § 1302 (codified at 42 U.S.C. § 18022 (2011)) (stating standards applicable to state Exchanges and qualified health plans), *with* 42 U.S.C. § 1396u-2 (2010) (stating standards applicable to Medicaid managed care plans and states that elect to furnish coverage through managed care arrangements). For a comprehensive review of similarities and differences, see DEBORAH BACHRACH ET AL., CTR. FOR HEALTH CARE STRATEGIES, MEDICAID MANAGED CARE: HOW STATES EXPERIENCE CAN INFORM EXCHANGE QUALIFIED HEALTH PLAN STANDARDS (2011), *available at* http://www.chcs.org/usr_doc/Medicaid_Managed_Care_and_QHP_Standards_final.pdf (paralleling the marketing, ease of access, safety net payments, emergency care, and grievance rights of qualified health plans and state Medicaid managed care).

77. 42 U.S.C. § 18021(a)(1)(C)(i) (2011).

78. ACA § 1311(c)(1)(C) (codified at 42 U.S.C. § 18031 (2011)). The term is defined to encompass all health care entities qualified to participate in a special prescription drug discount program authorized under the Public Health Service Act for providers furnishing a high volume of care to low income patients.

79. *See* BACHRACH ET AL., *supra* note 76, at 4.

80. ACA § 1311(c)(1)(D) (codified at 42 U.S.C. § 18031 (2011)).

Medicaid programs required accreditation, and, as noted, external review is a feature of Medicaid managed care.[81]

Because the conditions of participation applicable to qualified health plans and Medicaid managed care entities essentially cover the same policy ground, a logical step to encourage greater alignment would be to update the older Medicaid managed care standards (enacted in 1997) to reflect the ACA's newer expectations. While extending a state licensure requirement to the Medicaid product market would be a major departure from prior practices, states do have the power to establish specific licensure standards for issuers of Medicaid managed care products. This would thus enable states to accommodate community-based entities that desire to operate in the Exchange premium subsidy market, but lack the reserves maintained by large issuers. The licensure requirement would likely foster corporate affiliations between these smaller community-based plans and the larger licensed issuers so as to permit the entry of the community-based entities into the large crossover member market as a means of maintaining continuity of care.

Market alignment requires another step, namely addressing Medicaid's historically low provider payment rates (particularly for physician services) as the cause of the dearth of healthcare providers willing to participate in the Medicaid provider network. Although the health reform legislation contains a temporary payment boost for Medicaid primary care services, the reform is only two years in duration.[82] One solution might be to require plans operating in the crossover market to use Medicare payments as a floor. Such a requirement would have the effect of raising Medicaid provider payment rates while establishing a floor for Exchange provider payment levels. Another approach might be the creation of financial incentives in the form of more generous stop-loss levels for plans operating in the crossover market that boost physician payment levels.

5. Aligning Federal Financing

The ACA attempts to resolve the age-old problem of the federal government's role in Medicaid financing with an approach that, charitably put, is limited. In essence, states receive a highly enhanced federal contribution toward the Medicaid costs associated with reform, but only for certain populations,[83] who in truth (and contrary to Chief Justice Roberts'

81. *See* BACHRACH ET AL., *supra* note 76, at 9.

82. 42 U.S.C. § 1396a(a)(13)(C) (2011).

83. In broad terms, states will receive 100% federal funding over the 2014-2016 time period for medical assistance costs incurred for newly eligible populations (i.e., nonelderly adults ineligible for Medicare and not otherwise entitled to assistance because of their membership in one of the traditional coverage groups). Special rules apply to states that

characterization in *NFIB*[84]) can barely be distinguished in many cases from traditional populations. Indeed, a matter of a few dollars of monthly income would result in the movement of millions of parents from "traditional" to newly eligible categories. Coping with this situation will be extremely difficult, since it will require states to track the slightest income fluctuations of millions of low income adults, as daily work and family life change. The clear solution is a unified, enhanced federal contribution level covering all Medicaid populations who, depending on income, would qualify for premium subsidies through their state Exchanges. Regardless of whether attachment to Medicaid is based on low family income or disability, the group to target for enhanced federal payments is individuals who, based on income, will derive their coverage under either regime. This expanded approach to enhanced coverage (coupled with a new state option to allow Medicaid function as a secondary payer to Exchange coverage in the case of persons with disabilities) would blunt the potential for elimination of expanded Medicaid coverage for children and adults with disabilities while simplifying the accounting requirements for calculating federal payments to states. To be sure, this reform would require greater federal outlays on the Medicaid side. But to the extent that moving in this direction reduces states' incentive to eliminate coverage of all optional eligibility groups whose incomes surpass the Exchange threshold, a greater federal contribution could be expected to be a wash over the long term, since the Congressional Budget Office estimates a 50% differential between Exchange and Medicaid per capita coverage.[85]

III. FUTURE REFORM PROSPECTS

All legislative reform is evolutionary. The history of legislative health policy is no different — a seminal enactment followed by a succession of

already had expanded eligibility for the newly eligible population using the Social Security Act's special demonstration authority. *See* 42 U.S.C. §1315 (2011). Beginning in 2017, this enhanced funding will decline, ultimately remaining at 90% in 2020 and for years thereafter. ACA § 2001 (codified at 42 U.S.C. §1395d(y) (2011)). The normal federal contribution rate remains in place for traditional eligibility groups as well as for costs associated with plan administration.

84. *See* 132 S. Ct. at 2601.

85. CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE OF THE AFFORDABLE CARE ACT, UPDATED FOR THE SUPREME COURT'S RECENT DECISION 1, 4 (2012), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf (showing $9000 per capita in the Exchange and $6000 per capita in Medicaid). This difference is commonly attributable to Medicaid's depressed provider payment rates in relation to the private insurance market. *Id.* at 16. Of course, the federal government also would lose the value of state contributions to the cost of Medicaid coverage for previously eligible persons whose coverage was eliminated.

amendments aimed at modifying and revising earlier policy decisions or strengthening initial policy choices. Indeed, the ACA itself represents a series of legislative modifications to a host of existing laws in an attempt to make them operate in a more harmonious fashion: the Internal Revenue Code; the Public Health Service Act; the Employee Retirement Income Security Act; Medicare; and Medicaid. In some cases the legislative foray under the ACA entails the addition of entirely new legislative authority to an underlying law, as in the creation of health insurance Exchanges. More frequently, however, the ACA alters existing provisions of law in order to promote alignment with evolving policy choices.

Under normal circumstances, the types of reforms identified in this article would be considered part of the standard course of lawmaking. It took about 15 years of trying and at least four distinct sets of legislative amendments to create a universal Medicaid entitlement for low-income children and pregnant women, to strengthen their coverage, and to streamline and simplify the enrollment process for these populations. It is hardly surprising therefore, that the newest generation of Medicaid reforms will require further refinement. Medicaid is a vast program, with total expenditures surpassing $400 billion in FY 2010 and a projected enrollment approaching 80 million people by 2020.[86] It is one of the most complex laws ever enacted by Congress; indeed, no less a judge than Henry Friendly famously termed its provisions "almost unintelligible to the uninitiated."[87] The need for further amendment and refinement thus should hardly come as a surprise.

But, of course, this is no ordinary time for Medicaid. The fury over Medicaid has never been higher, fueled by costs, ideology, and an unprecedented level of political animus. Medicaid's very legislative structure — national policy goals achieved through federal investments that build on and strengthen state efforts to aid the medically indigent and vulnerable — has been thrown into uncertainty by *NFIB v. Sebelius,* whose undefined reach into the future of federal spending programs is the subject of intense scholarship.[88] Despite public opinion polls underscoring its popularity with

86. CTRS. FOR MEDICARE & MEDICAID SERVS., OFFICE OF THE ACTUARY, 2010 ACTUARIAL REPORT ON THE FINANCIAL OUTLOOK FOR MEDICAID iii-iv (2010), *available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/MedicaidReport2010.pdf.

87. And this was more than 35 years ago, when the program was far simpler. *See* Friedman v. Berger, 547 F.2d 724, 727 n.7 (2d Cir. 1976).

88. *See* Huberfield, *supra* note 3 (discussing challenges in the future of Medicaid created by the *NFIB* decision); *see also* Bagenstos, *supra* note 3 (describing the uncertainties brought by interpretations of this case's decision).

the American public,[89] Medicaid remains exceptionally vulnerable to attack in what is anticipated to be a seminal battle over its future and that of other social welfare entitlements in the wake of the 2012 Presidential election.

Following the watershed election in November, three possible scenarios await Medicaid in the 113th Congress. The first — highly unlikely — is to make only minor structural modifications in the program while attempting to reduce spending in the $100 billion to $200 billion range (modest in a program projected to spend trillions in federal funds alone over the coming decade) by simply cutting federal funding to states. This is the action Congress took as a part of the Omnibus Reconciliation Act of 1981, essentially applying a three percent discount to the payments they otherwise owed state programs.[90] In 1984, the 1981 payment reductions were eliminated and federal funding was restored (indeed, in periods of recession, federal Medicaid funding has been increased).[91] States were given certain added flexibility measures as part of the 1981 reductions, but not such expansive powers that the basic framework of the entitlement to coverage was structurally up-ended.

The two alternatives to the aforementioned minor surgery are far more invasive. The first is a proposal to "block grant" Medicaid. The second is a proposal to fundamentally alter Medicaid's open-ended financing structure through the use of per capita caps. In both cases, it is likely that the "baseline" used to estimate the size of the reductions and the impact of the savings will be Medicaid as restructured under the ACA. In other words, the starting point will be a program that assumes elimination of Medicaid's historic barrier against federal funding to cover all low income people. Whichever pathway Congress chooses however, states would be expected to achieve the Medicaid reform goals with dramatically less federal financing.

Were Congress to choose what is popularly termed a "block grant"[92] pathway, federal expenditures per state would be subject to annual

89. *See, e.g.*, KAISER FAMILY FOUND., KAISER HEALTH TRACKING POLL: MAY 2011 PUBLIC OPINION ON HEALTH CARE ISSUES 1 (2011) (finding 60% public support for preserving Medicaid as an entitlement program and only 13% support for major reductions). These figures are not significantly different from public opinion regarding Medicare reforms.

90. SPECIAL COMM. ON AGING, OMNIBUS BUDGET RECONCILIATION ACT OF 1981, at 10 (Comm. Print 1981).

91. *See, e.g.*, American Adjustment and Recovery Act of 2009, Pub. L. No. 111-5, 123 Stat. 115, 116, 489-90 (codified at 42 U.S.C. § 1396b (2010)) (discussing incentives for Medicaid in an act to stimulate economic recovery).

92. Actually the term is probably not right. In a block grant, federal payments are made in advance of state expenditures, with limited state accountability for results. My own betting is that federal Medicaid spending would remain an after-the-fact event, with continuing tight federal controls over what is considered a qualifying state expenditure. This type of tight

aggregate caps, with concomitant evisceration of federal legal requirements in order to give states broad leeway in how they absorb the loss of funds. The enormity of the funding loss, as well as the difficulties of apportionment given the differences in states' fiscal starting points under a block grant, both have led to the repeated abandonment of the proposal.[93]

The latest version of this repeatedly discredited idea shows up in a 2012 proposal issued by the United States House of Representatives Budget Committee contained in *The Path to Prosperity: A Blueprint for American Renewal*.[94] The proposal, virtually identical to one put forward in 2011, proposes to repeal the ACA Medicaid expansions and to block grant the remaining program, with growth indexed to inflation and population growth. The Committee asserts that this approach would restore state flexibility and autonomy while improving provider payments and consumer choice. The proposal offers no insight as to how states and the federal government will cope with the changes in eligibility, enrollment, benefits and coverage, consumer protections, and administration requirements that the Committee favors. The Committee estimates that the block grant proposal will reduce federal Medicaid outlays by $810 billion over the FY 2013-2023 time period, not counting the nearly $1 trillion in savings achieved by repealing the ACA Medicaid expansion.[95]

Analysis suggests that the projected $810 billion in losses resulting from placing arbitrary limits on federal Medicaid spending through a block grant would be the least level of impact that states could anticipate.[96] Were state Medicaid costs to rise faster than the proposed growth factor, the level of true loss relative to Medicaid's historic open-ended financing system would be far greater. The losses — which project to about 22% over the 2012-

control is not unexpected in a very large program and is the method used in the case of Section 1115 demonstrations that award states flexibility.

93. *See* Jeanne M. Lambrew, *Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals*, 83 MILBANK QUARTERLY 41, 46 (2005) (examining the potential impact had block grant legislation passed by Congress but vetoed by President Clinton succeeded). The author estimated as much as a 25% decline in federal Medicaid funding, with highly differential impacts among the states given differences in underlying economic conditions, health care cost factors, and other considerations. *Id.* at 51-52, 54.

94. PAUL RYAN, HOUSE OF REPRESENTATIVES BUDGET COMM., THE PATH TO PROSPERITY: A BLUEPRINT FOR AMERICAN RENEWAL 14 (2012), *available at* http://budget.house.gov/uploaded files/pathtoprosperity2013.pdf.

95. *Id.* at 42; *see also Report: GOP proposals would cut $1.7T from Medicaid,* THE ADVISORY BOARD COMPANY (Oct. 24, 2012), http://www.advisory.com/Daily-Briefing/2012/10/24/GOP-proposals-would-cut-1-7-T-from-Medicaid.

96. EDWIN PARK & MATT BROADDUS, CTR. ON BUDGET & POL'Y PRIORITIES, WHAT IF CHAIRMAN RYAN'S MEDICAID BLOCK GRANT HAD TAKEN EFFECT IN 2001?: FEDERAL MEDICAID FUNDS WOULD HAVE FALLEN BY 35% OR MORE IN MOST STATES, BY HALF IN SOME, BY 2010, at 1 (2012), *available at* http://www.cbpp.org/files/4-20-12health.pdf.

2022 time period and a 34% reduction in 2022 alone[97] — would mask much steeper proportional losses in certain states. The state programs that risk the greatest relative losses are those that stand to gain the most proportionately from the ACA expansions. The impact of the loss would be greatest because these states, such as Texas, Florida, and other southern and southwestern states have high uninsured populations and thus stand to gain the most from coverage expansion.[98] A prominent analysis released in the fall of 2012 determined that under a plan that both repeals the Medicaid expansion and block grants the program, enrollment would fall by about 35 million persons by 2022.[99] Furthermore, since the federal government would presumably continue to make Medicaid payments only in connection with approved state expenditures, the pattern of federal disallowances and recoveries and constant state disputes that characterizes the program today[100] would be expected to persist. In other words, block grant funds would not be free money. Indeed, if a 2012 congressional flap over whether HHS has the legal authority to permit states to modify the rigid work requirements of the TANF block grant program is any guide,[101] tough federal spending rules, coupled with ongoing and aggressive federal audit practices will remain core features of any successor program. It is fair to say that the desire of federal lawmakers to constrain federal financial support for state programs applies regardless of whether the mechanism for a funds transfer is open-ended or subject to limits. Indeed, were legislation limiting

97. *Id.* at 3.

98. *See* JOHN HOLAHAN ET AL., KAISER FAMILY FOUND., HOUSE REPUBLICAN BUDGET PLAN: STATE-BY-STATE IMPACT OF CHANGES IN MEDICAID FINANCING 7 (2011). For example, Florida's ten-year loss reached nearly 44% of what it would have received, while Vermont, a more generous state, would experience a 26% loss below expected levels. *Id.* at 6 fig.3.

99. SARA R. COLLINS ET AL., COMMONWEALTH FUND, HEALTH CARE IN THE 2012 PRESIDENTIAL ELECTION: HOW THE OBAMA AND ROMNEY PLANS STACK UP 28, at Ex. 4 (2012), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Oct/1636_Collins_hlt_care_2012_presidential_election_FINAL_CPI_revised_10_02_2012.pdf.

100. States have extensive appeals rights under Medicaid in furtherance of their entitlement interest in payment. *See* 42 C.F.R. § 430.42 (2012) (setting forth the procedural requirements for review of federal payment disallowances).

101. *See* Letter from Lynn H. Gibson, General Counsel, Gov't Accountability Office, to Sen. Orrin Hatch, Ranking Member, Senate Comm. on Finance, and Sen. Dave Camp, Chairman, House of Representatives Comm. on Ways and Means 6 (Sept. 4, 2012), *available at* http://www.gao.gov/assets/650/647778.pdf (regarding Congressional power to review the Secretary's decision to permit waivers of the TANF work requirements by states that seek to establish an alternative approach to the terms of the statute). For a sense of the detailed federal oversight procedures used to govern state and tribal TANF spending, see DEP'T HEALTH & HUMAN SERVS., TRIBAL TANF AND CCDF GUIDE TO FINANCIAL MANAGEMENT, GRANTS ADMINISTRATION, AND PROGRAM ACCOUNTABILITY 13-15 (2004), *available at* http://www.acf.hhs.gov/sites/default/files/occ/fmgapa.pdf (explaining the types of federal payment disallowances that can be applied to governmental TANF recipients).

federal funding also to include provisions altering state performance requirements in the areas of eligibility, coverage, payment, and management (and presumably this will be the case), federal oversight could become more aggressive given the potential for looser standards to result in less rigorous state spending management and oversight. Put another way, a race to the bottom does not make the green eyeshades irrelevant.

Furthermore, Medicaid is heavily embedded in state economies as a result of the complex financing arrangements on which the program rests (a combination of general revenues, special taxes, and transfers among units of governments that share responsibility for the operation of public healthcare systems serving Medicaid beneficiaries along with other low income populations).[102] As a result, a block grant promises to set in motion a great economic unraveling as the losses spread through local public health economies, rolling over public healthcare institutions, school health systems, public health clinics, and public, community-based programs for persons with disabilities. This, of course, is where the strong public response to Medicaid is so telling: for millions of families, Medicaid is an essential part of the fabric of daily life.

In view of the enormous consequences flowing from a block grant, the more plausible option, and one being discussed with increasing intensity, is what is known as a "per capita cap." Under this approach, the federal government would cease to contribute a share of a state's total program spending.[103] Instead, the federal contribution would look more like a defined per capita contribution up to a fixed dollar amount per beneficiary served. While this approach does not so dramatically leave states strapped of resources to provide care for the tens of millions of low income Medicaid beneficiaries and to support the providers that serve those beneficiaries, it nonetheless raises numerous problems of its own.

The first is the difficulty of fashioning a defined contribution methodology that properly accounts for health risks given states' limited coverage experience with low income adults who are not parents of minor children. Many newly eligible persons will be healthy adults, but others will have extensive physical and mental health problems. The lack of cost experience, coupled with the general confusion regarding how to absorb the losses associated with a per capita cap, can be expected to dampen most states' interest in Medicaid expansion, even if expansion with federal funding remains an option.

102. For a review of federal/state financial relationships and their effect on local health economies, *see* MACPAC, *supra* note 74, ch. 3.

103. EDWIN PARK & MATT BROADDUS, CTR. ON BUDGET & POL'Y PRIORITIES, MEDICAID PER CAPITA CAP WOULD SHIFT COSTS TO STATES AND PLACE LOW INCOME BENEFICIARIES AT RISK 1 (2012), *available at* http://www.cbpp.org/files/10-4-12health.pdf.

A second problem with a defined contribution model is the weakness of the methodology in relation to the actual cost of care. A pandemic, an unanticipated public health crisis such as the HIV/AIDS epidemic that swept the nation in the 1980s, a major natural or manmade disaster such as Hurricane Katrina or the World Trade Center attack, all can throw off actuarial projections that reflect normal conditions, as can major technology breakthroughs that create game-changing conditions for the healthcare system (for example, national spending on prescription drugs grew by 15% in 1998 alone).[104] However, policymakers could fortify the defined contribution model with proper provisions to account for such anomalies.

A third problem is that a per capita cap essentially takes a snapshot of state Medicaid spending as it exists at a specified moment in time (i.e., the baseline). Thus, states that have low per capita spending, either because of low pricing, limited coverage, or both, are in essence locked into artificially depressed caps. States that did not previously cover certain disabled populations but desire to add coverage would have no financial history against which the cap could be measured and so would be exposed to whatever unsupported methodology is proposed. States that experience large annual leaps in per beneficiary costs would have no means of recouping their losses, since the cap would be set to grow at a fixed rate (e.g., inflation plus one percent). And of course, quite problematically, once set, the cap could be lowered in the face of budgetary or other constraints. Moreover, in exchange for absorbing the impact of a per capita cap, states would demand far more flexibility in Medicaid than they now enjoy: over eligibility, enrollment, coverage, benefits, payments, and management requirements and safeguards.

The final problem is the reality of Medicaid spending. The great driver of Medicaid spending today is enrollment. Pricing, which is quite depressed, and per capita costs, which are state-controlled through outlays and utilization, particularly in the case of costly populations, do not factor in as much. Indeed, so tightly managed are Medicaid expenditures that per enrollee growth rates for the coming decade are expected to be at GDP.[105] Viewed through this lens, it becomes evident that a per capita cap essentially saves nothing unless it is held below even the rate of GDP growth. Thus, while it certainly would be possible to embed a number of the reforms outlined in this article into a per capita cap approach to federal Medicaid spending, it is also true that states' interest in improving its performance might be distinctly dampened by their need to contain costs below even minimal rates of inflation.

104. *Id.* at 6.

105. John Holahan & Stacey Morrow, *Medicare and Medicaid Spending Trends and the Deficit Debate*, 367 NEW ENG. J. MED. 393, 394 (2012).

IV. CONCLUSION

The ACA made seminal Medicaid reforms while triggering a need for further alignment. As the Act has moved toward implementation, the need for additional reform has become clearer, an inevitability in any remarkably complex piece of legislation. Whether Medicaid's next 50 years will witness its ongoing transformation, through continued federal investment, into an effective component of a comprehensive scheme of universal coverage or instead, its decline ultimately will be an intensely political determination rather than one driven by health policy. The policy argument pleads for continued strengthening; but the enduringly ferocious politics of Medicaid may be moving the program along a far different pathway.