

6-1-2014

# States' Decisions Not to Expand Medicaid

Mark A. Hall

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## Recommended Citation

Mark A. Hall, *States' Decisions Not to Expand Medicaid*, 92 N.C. L. REV. 1459 (2014).Available at: <http://scholarship.law.unc.edu/nclr/vol92/iss5/3>

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# STATES' DECISIONS NOT TO EXPAND MEDICAID\*

MARK A. HALL\*\*

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## INTRODUCTION

The Patient Protection and Affordable Care Act (“ACA”)<sup>1</sup> presents states with two major decisions: (1) whether to create a state-based exchange for the purchase of subsidized private health insurance,<sup>2</sup> and (2) whether to expand Medicaid, the joint state/federal government health insurance program for the poor.<sup>3</sup> Expanded Medicaid would cover all citizens and long-time legal residents near or below the federal poverty line.<sup>4</sup> The ACA itself gives states the first option.<sup>5</sup> It provides that, if states opt not to run their own insurance exchanges, the federal government will do this for them.<sup>6</sup> The Supreme Court gave states the second option. In *National Federation of Independent Business v. Sebelius*,<sup>7</sup> it held that the ACA’s expansion of Medicaid does not violate state sovereignty,

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

2. *See id.* § 1321, 124 Stat. at 186–87 (codified at 42 U.S.C. § 18041 (2012)).

3. *See id.* § 2001, 124 Stat. at 271–79 (codified at 42 U.S.C. § 1396a (2012)).

4. *See id.* § 2001(a)(1)(C), 124 Stat. at 271 (codified at 42 U.S.C. § 1396(a)(10)(A)(i)(VIII) (2012)) (expanding coverage to anyone under sixty-five years of age whose income falls within a certain percentage of the federal poverty line).

5. *See id.* § 1321(b), 124 Stat. at 186 (codified at 42 U.S.C. § 18041(b) (2012)).

6. *Id.* § 1321(c)(1), 124 Stat. at 186 (codified at 42 U.S.C. § 18041(c)(1) (2012)).

7. 132 S. Ct. 2566 (2012).

but only if states are allowed to opt out of the expansion without sacrificing their current Medicaid funding.<sup>8</sup>

Contrary to most initial expectations, over half the states have refused to create their own insurance exchanges,<sup>9</sup> and roughly half have refused to expand Medicaid.<sup>10</sup> These decisions clearly follow political lines. All the states that refused both of these options are led by Republican governors or legislative majorities.<sup>11</sup> Still, the extent of red-state resistance to the ACA's core structures is surprising. States that run their own insurance exchanges have much more local control over the very kind of important policy and regulatory matters that conservatives vociferously complain the federal government usurps.<sup>12</sup>

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8. See *id.* at 2607–08.

9. Sarah Kliff, *It's Official: The Feds Will Run Most Obamacare Exchanges*, WASH. POST WONKBLOG (Feb. 18, 2013, 10:37 AM), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/02/18/its-official-the-feds-will-run-most-obamacare-exchanges/>. Nineteen states rely on the federally facilitated marketplace: Alabama, Alaska, Arizona, Florida, Georgia, Indiana, Louisiana, Mississippi, Missouri, New Jersey, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming. See *State Action to Establish Health Insurance Marketplaces*, COMMONWEALTH FUND, <http://www.commonwealthfund.org/Maps-and-Data/State-Exchange-Map.aspx> (last visited May 5, 2014). Seven other states also rely on the federally facilitated marketplace but conduct their own plan management: Kansas, Maine, Montana, Nebraska, Ohio, South Dakota, and Virginia. *Id.*

10. Sabrina Tavernise & Robert Gebeloff, *Millions of Poor Are Left Uncovered by Health Law*, N.Y. TIMES (Oct. 2, 2013), [http://www.nytimes.com/2013/10/03/health/millions-of-poor-are-left-uncovered-by-health-law.html?hp&\\_r=1&](http://www.nytimes.com/2013/10/03/health/millions-of-poor-are-left-uncovered-by-health-law.html?hp&_r=1&). The states that have no plan to expand Medicaid at this time are: Alabama, Alaska, Florida, Georgia, Idaho, Kansas, Louisiana, Maine, Mississippi, Montana, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming. See *State Decisions on Health Insurance Marketplaces and the Medicaid Expansion, 2014*, HENRY J. KAISER FAMILY FOUND., <http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/> (last visited May 5, 2014). The Kaiser Commission on Medicaid and the Uninsured classifies five states as being in “Open Debate,” meaning the states have no plans to expand Medicaid but have recent public statements made by the Governor, have issued a waiver proposal, or have passed a Medicaid expansion bill in at least one chamber of the legislature: Indiana, Missouri, Pennsylvania, Utah, and Virginia. *Id.*

11. See David K. Jones & Scott L. Greer, *State Politics and the Creation of Health Insurance Exchanges*, 103 AM. J. PUB. HEALTH e8, e9 (2013); *Where the States Stand on Medicaid Expansion*, ADVISORY BOARD COMPANY (Jan. 24, 2014, 11:13 AM), <http://www.advisory.com/Daily-Briefing/Resources/Primers/MedicaidMap>; see also Lawrence R. Jacobs & Timothy Callaghan, *Why States Expand Medicaid: Party, Resources, and History*, 38 J. HEALTH POL. POL'Y & L. 1023, 1025 (2013) (analyzing various political factors that correlate with states' decisions about whether to embrace the ACA).

12. See David K. Jones et al., *Pascal's Wager: Health Insurance Exchanges, Obamacare, and the Republican Dilemma*, 39 J. HEALTH POL. POL'Y & L. 97, 130 (2014) (“[M]any Republican-led states paradoxically protested a federal ‘takeover’ of the health care system by giving Washington the power to take over exchanges in their states.”).

Therefore, conservative opposition to state-based exchanges, which necessarily defaults to federal control, is at odds with their professed political and ideological principles.<sup>13</sup> Instead, this refusal appears to be based on the hope that, by not establishing state-based exchanges, ACA opponents can raise the legal argument that residents of states without state-based exchanges lose their eligibility for federal subsidies to purchase private insurance.<sup>14</sup>

As for Medicaid expansion, the surprise in failing to expand is not political; it is simply the financial fact that refusing to expand foregoes vast sums of federal funding. Conventionally, the federal government has paid for at least half of states' Medicaid's costs, but, for the expansion population, the ACA generously commits the federal government to fund 100% of the costs in the first year (2014), scaling back slightly to 90% of the costs by year 2020.<sup>15</sup> Thus, states that refuse to expand Medicaid are declining a tremendous opportunity to leverage their own limited resources to produce more than a nine-fold return on investment. Moreover, the very states that are making this choice are the states that have the most to gain from expansion.<sup>16</sup> Their current Medicaid programs are, on the whole, the leanest in the country, and so they would gain the most in using federal funds to raise their programs to parity with other states.<sup>17</sup>

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13. See LAWRENCE R. JACOBS & THEDA SKOCPOL, *HEALTH CARE REFORM AND AMERICAN POLITICS* 90–91 (rev. ed. 2012) (describing the conservative about-face that occurred when health care reformers attempted to incorporate health insurance exchanges into the ACA).

14. Although a federal court in the District of Columbia recently rejected this argument, see *Halbig v. Sebelius*, CV 13-0623, 2014 WL 129023, at \*1, \*18 (D.D.C. Jan. 15, 2014), similar challenges are pending in other jurisdictions. See Jonathan Weisman & Sheryl Gay Stolberg, *G.O.P. Maps Out Waves of Attacks Over Health Law*, N.Y. TIMES (Nov. 20, 2013), [http://www.nytimes.com/2013/11/21/us/politics/gop-maps-out-waves-of-attacks-over-health-law.html?\\_r=0](http://www.nytimes.com/2013/11/21/us/politics/gop-maps-out-waves-of-attacks-over-health-law.html?_r=0).

15. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001(a)(3), 124 Stat. 119, 272 (2010) (codified at 42 U.S.C. § 1396d(y)(1)(A)–(E) (2012)); see also Sara Rosenbaum & Timothy M. Westmoreland, *The Supreme Court's Surprising Decision on the Medicaid Expansion: How Will the Federal Government and States Proceed?*, 31 HEALTH AFF. 1663, 1665 (2012) (summarizing funding commitments made by the federal government in the ACA).

16. See MATTHEW BUETTGENS & MARK A. HALL, URBAN INST., WHO WILL BE UNINSURED AFTER HEALTH INSURANCE REFORM? 4 fig.2 (2011), available at <http://www.urban.org/uploadedpdf/1001520-Uninsured-After-Health-Insurance-Reform.pdf> (finding that all southern states, except for Virginia, would experience a double-digit decline in the uninsurance rate if the ACA were fully implemented, while no states in the Northeast would experience such a large decline).

17. See *id.*; JOHN HOLAHAN ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, THE COST OF NOT EXPANDING MEDICAID 9 fig.9 (2013), available at <http://kff.org/medicaid/report/the-cost-of-not-expanding-medicaid/>.

While expanding states will increase their current federal funding by only about 16% over the first ten years of the ACA, non-expanding states will forgo increases of federal funding of more than 25% during that same period.<sup>18</sup> In addition, hospitals in these states have the most to lose. The ACA, assuming that states would expand Medicaid, cuts \$18 billion in existing federal funding to hospitals for their uncompensated care for low-income uninsured patients.<sup>19</sup> Despite losing this funding, hospitals are still required to treat uninsured patients in emergencies and nonprofit hospitals are required to provide charity care to the uninsured.<sup>20</sup> Therefore, failure to expand Medicaid puts hospitals in especially dire financial straits.

To understand these issues fully, a word or two more is needed about how Medicaid is structured. When originally enacted in 1965,<sup>21</sup> Medicaid was built around traditional categories of welfare recipients.<sup>22</sup> The common theme was to designate who among the poor is most deserving of assistance: those who are also elderly, disabled, children, pregnant, or single parents.<sup>23</sup> Federal standards set minimum eligibility standards that states were free to exceed, which many have done to varying extents.<sup>24</sup> Yet, many have not.<sup>25</sup> This state-

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18. See BUETTGENS & HALL, *supra* note 16, at 5.

19. See John A. Graves, *Medicaid Expansion Opt-Outs and Uncompensated Care*, 367 NEW ENG. J. MED. 2365, 2365 (2012) (noting that the \$18.1 billion reduction in the Medicaid Disproportionate Share Hospital payments represents a 75% decrease from the current level of \$22.1 billion); see also Mitchell H. Katz, Commentary, *Future of the Safety Net Under Health Reform*, 304 JAMA 679, 679 (2010) (discussing the threat to the safety-net hospitals that these cuts represent).

20. See 42 U.S.C. § 1395dd (2012) (imposing medical screening and stabilizing treatment requirements and imposing civil penalties of \$50,000 for not complying with this responsibility); Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9007, 124 Stat. 119, 855 (2010) (codified at I.R.C. § 501(r) (2012)) (imposing limitations on charges and financial assistance requirements for hospitals to qualify as a 501(c)(3) charitable hospital organization).

21. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286. See generally KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID: A PRIMER (2013), available at <http://kff.org/medicaid/issue-brief/medicaid-a-primer/> (providing information on the scope, structure, and operations of the Medicaid system).

22. KAISER COMM'N ON MEDICAID & THE UNINSURED, *supra* note 21, at 1 (explaining that Medicaid was originally conceived as a medical assistance supplement for people receiving cash welfare assistance).

23. See *id.*

24. See § 1396a(a)(10)(A)(ii) (giving states the opportunity to expand coverage to those not listed in Medicaid's original coverage); KAISER COMM'N ON MEDICAID & THE UNINSURED, *supra* note 21, at 1 (noting that states have considerable flexibility regarding eligibility, benefits, provider payments, delivery systems, and other aspects of the program).

25. See KAISER COMM'N ON MEDICAID & THE UNINSURED, *supra* note 21, at 5; Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 435 (2011).

level flexibility has produced a complex tapestry of coverage rules across the nation.<sup>26</sup>

The ACA's major reform of Medicaid is to expand coverage to all people at or below 138% of the federal poverty level,<sup>27</sup> evening out the wide variation among states and including all citizens who are near poverty, regardless of family composition or reason for poverty.<sup>28</sup> For most states, this will be a substantial expansion, estimated to cover ten million more people who are currently uninsured, and it will be funded mostly with federal revenues.<sup>29</sup> But, states that refuse to expand Medicaid create an abrupt cliff in the ACA's benefits. Sliding scale subsidies to purchase private insurance increase to cover essentially the entire cost of insurance as a person's income declines toward the federal poverty level.<sup>30</sup> The ACA, however, does not authorize private insurance subsidies for people below the poverty line because Congress assumed that expanded Medicaid would cover the poor.<sup>31</sup> Therefore, a person earning one dollar less than the federal poverty line receives no help from the ACA if a state does not expand Medicaid, but a person who makes one dollar above the federal poverty line receives virtually free insurance.<sup>32</sup>

If Medicaid expansion were funded mainly by each state, we might better understand a willingness to tolerate this inequity in order to reduce taxpayer burden. But, refusing expansion does nothing of the sort. Because expansion is funded almost entirely through federal taxes,<sup>33</sup> taxpayers in refusing states receive almost no relief.<sup>34</sup> Instead,

26. See Huberfeld, *supra* note 25, at 435.

27. See Avery Johnson, *What You Need to Know About the Affordable Care Act*, WALL ST. J. (Sept. 28, 2013, 8:23 PM), <http://online.wsj.com/news/articles/SB10001424052702304213904579093371338509610>. The statute actually states the level as 133%, but the Modified Adjusted Gross Income ("MAGI") disregards 5% of an applicant's income, which equates to 138% of the federal poverty line. See *Medicaid Expansion*, AM. PUB. HEALTH ASS'N, <http://www.apha.org/advocacy/Health+Reform/ACAbasics/medicaid.htm#Medi5> (last visited May 5, 2014).

28. See KAISER COMM'N ON MEDICAID & THE UNINSURED, *supra* note 21, at 1–2.

29. See HOLAHAN ET AL., *supra* note 17, at 7.

30. See Phil Galewitz, *In States That Don't Expand Medicaid, Some of the Uninsured May Still Get Help*, KAISER HEALTH NEWS (Aug. 11, 2013), <http://www.kaiserhealthnews.org/Stories/2013/August/12/income-projections-low-income-Obamacare-state-medicaid-marketplace-exchange.aspx>.

31. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1401(a), 124 Stat. 119, 213–15 (2010) (codified at I.R.C. § 36B (2012)).

32. See Galewitz, *supra* note 30.

33. See BRANDON HEMMINGS ET AL., CTR. FOR HEALTHCARE RESEARCH & TRANSFORMATION, *THE IMPACT OF ACA TAXES AND FEES 1–3* (2013), available at <http://www.chrt.org/assets/price-of-care/CHRT-Issue-Brief-August-2013.pdf> (identifying

they continue to pay increased taxes under the ACA, in order to fund Medicaid benefits enjoyed only by citizens of expanding states.<sup>35</sup>

Why would conservative political leaders want to refuse \$50 billion a year of federal benefits,<sup>36</sup> even though their own citizens still pay the same federal taxes that fund these benefits for other states? And, why do this when the health and lives of millions of poor people are at stake? One distinct possibility is implicit racism. This degree of pitched opposition by states to a major federal domestic initiative has not been seen since the civil rights era of the 1960s. Then, too, states opposed federal intervention (for integration) based on states' rights principles.<sup>37</sup> But, the true motives were patent. It is certainly possible that similar motives are among the mix of sentiments shared by at least some opponents of Medicaid expansion. President Obama's political standing, of course, is sharply divided by race;<sup>38</sup> thus, it is no surprise that blacks support the ACA much more strongly than whites.<sup>39</sup> The inference that these views are tinged with racism is not based simply on speculation. Social psychologists have studied the extent to which views about President Obama's health care reform plan are influenced by racial prejudice, distinct from party preference or general social ideology. One study found, for instance, that measures of implicit racial bias were associated with views on President Obama's health reform plan, but not with an identical plan that the study attributed to former President Clinton.<sup>40</sup>

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the federal taxes used to offset the costs of the premium subsidies and Medicaid expansion).

34. See Sarah Baron, *10 Frequently Asked Questions About Medicaid Expansion*, CENTER FOR AM. PROGRESS (Apr. 2, 2013), <http://www.americanprogress.org/issues/healthcare/news/2013/04/02/58922/10-frequently-asked-questions-about-medicaid-expansion/>.

35. See *id.*

36. See HOLAHAN ET AL., *supra* note 17, at 7.

37. See generally TAYLOR BRANCH, *PILLAR OF FIRE: AMERICA IN THE KING YEARS 1963–65* (1998) (analyzing the states' rights argument advanced by mostly southern states and the resulting tensions over the federal role within the state).

38. In the 2012 presidential election, 93% of black voters voted for Obama, compared with only 39% of white voters. See *Decision 2012, Presidential Election Results*, NBC NEWS, <http://elections.nbcnews.com/ns/politics/2012/all/president/> (last updated Feb. 3, 2014).

39. According to one survey, for instance, three quarters of blacks approve of Obama's health care law, whereas fewer than 40% of whites approve. See Michael Ramlety & Kyle Dropp, *August 2013 Tracking Poll Memo*, MORNING CONSULT (Sept. 4, 2013), <http://themorningconsult.com/2013/09/august-2013-tracking-poll-memo/>.

40. Eric D. Knowles et al., *Racial Prejudice Predicts Opposition to Obama and His Health Care Reform Plan*, 46 J. EXPERIMENTAL SOC. PSYCHOL. 420, 422–23 (2010).

More than simply politics and racial bias, blacks' support for the ACA is rooted in what they stand to gain, especially from Medicaid expansion. People of color make up about 60% of the country's uninsured population eligible for expanded Medicaid.<sup>41</sup> Among black adults who are uninsured, almost two-thirds would qualify for expanded Medicaid.<sup>42</sup> Whites make up only 40% of low-income uninsured people, and only 42% of uninsured white adults would qualify for expanded Medicaid.<sup>43</sup> These disparities suggest that politicians who oppose Medicaid expansion will do more damage to their black than their white constituencies.<sup>44</sup>

I hasten to say that I do not ascribe racist motives to anyone in particular, or in general. I only stress that appearances here are disturbing. Therefore, to reject the racist hypothesis, we must look elsewhere for a convincing explanation to deny federal benefits that would save lives and improve health. One obvious reason, given the current political climate, is raw political spite. Many Republican officials believe that the ACA's enactment was not fully legitimate because it lacked bipartisan support and because Democratic leaders used procedural rules to overcome a filibuster threat in the Senate.<sup>45</sup> Some state lawmakers and regulators proudly proclaim their opposition to the ACA, and trumpet their purposefully obstructive strategies.<sup>46</sup> Others, however, hide behind a veil of public policy

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41. KAISER COMM'N ON MEDICAID & THE UNINSURED, THE IMPACT OF CURRENT STATE MEDICAID EXPANSION DECISIONS ON COVERAGE BY RACE AND ETHNICITY 7 (2013), available at <http://kff.org/disparities-policy/issue-brief/the-impact-of-current-state-medicaid-expansion-decisions-on-coverage-by-race-and-ethnicity/>.

42. VERNON SMITH ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, HEALTH COVERAGE FOR THE BLACK POPULATION TODAY AND UNDER THE AFFORDABLE CARE ACT 4 (2013).

43. SAMANTHA ARTIGA ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, THE IMPACT OF THE COVERAGE GAP IN STATES NOT EXPANDING MEDICAID BY RACE AND ETHNICITY 3 fig.4 (2013), available at <http://kff.org/disparities-policy/issue-brief/the-impact-of-the-coverage-gap-in-states-not-expanding-medicaid-by-race-and-ethnicity/>; SMITH ET AL., *supra* note 42, at 7, 9.

44. See ARTIGA ET AL., *supra* note 43, at 4 (reporting that over half of the people who lose eligibility due to not expanding are people of color).

45. See JACOBS & SKOCPOL, *supra* note 13, at 114–19 (examining the last minute deals and maneuvers required to enact the ACA without Republican votes); Elizabeth Rigby et al., *Party Politics and Enactment of "Obamacare": A Policy-Centered Analysis of Minority Party Involvement*, 39 J. HEALTH POL. POL'Y & L. 57, 82 (2013) (noting the marginalization of Republicans in the final stages of enacting the ACA).

46. See, e.g., Jay Bookman, Editorial, *Ga. Insurance Chief Brags About Sabotage of ObamaCare*, ATLANTA J. CONST. (Aug. 29, 2013, 8:22 AM), <http://www.ajc.com/weblogs/jay-bookman/2013/aug/29/ga-insurance-chief-brags-about-sabotage-obamacare/> (quoting the Georgia Commissioner of Insurance bragging that his office was doing "[e]verything in [its] power to be an obstructionist"); Editorial, *Perry's Latest Move Against Obamacare to*



neutrality.<sup>47</sup> They claim that decisions to reject states' options under the ACA are driven by a thoughtful consideration of what is in the best interests of the states' citizenry, and not by politics.<sup>48</sup> Such claims of policy legitimacy merit closer attention—if only because their superficial logic seems appealing, or because their questionable points have been repeated so frequently.

This Article examines more closely the leading explanations given by conservative politicians and policy analysts for refusing to expand Medicaid. First, opponents argue that Medicaid is bad for patients because it pays providers too little reimbursement or suffers from other design and implementation flaws. Second, opponents argue that, despite major federal funding, Medicaid expansion is too expensive for states to undertake. Finding that both reasons lack factual foundation or plausible logic, the Article concludes that non-expanding states appear to be motivated either by the political aim of undermining President Obama's signature domestic program, or by the rudimentary ideological aim of opposing redistribution through taxation, even to maintain health and save lives.

### I. IS MEDICAID BAD FOR PATIENTS?

Among the troubling arguments advanced by states rejecting federal Medicaid funds, the most pernicious is that Medicaid is actually bad for its beneficiaries, or, at best, that Medicaid does no good and so is simply a waste of money.<sup>49</sup> Some conservative policy advocates claim either that people are worse off being on Medicaid than being uninsured, or that they would be substantially better off if the government fundamentally restructured Medicaid or replaced it

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*Obstruct, Not Protect*, FORT WORTH STAR-TELEGRAM (Sept. 19, 2013), <http://www.star-telegram.com/2013/09/18/5174184/perrys-latest-move-against-obamacare.html> (identifying “roadblocks” erected by Governor Rick Perry of Texas, such as imposing new regulations on the federally trained “navigators” who volunteer to help citizens enroll in coverage).

47. For an example of some of the reasons not to adopt the Medicaid expansion being proffered by conservative academics, see Joseph Antos, *The Medicaid Expansion Is Not Such a Good Deal for States or the Poor*, 38 J. HEALTH POL. POL'Y & L. 179 (2013).

48. See Elizabeth Weeks Leonard, *Crafting a Narrative for the Red State Option*, 102 KY. L.J. 381, 407–09 (2014). See generally Benjamin D. Sommers & Arnold M. Epstein, *U.S. Governors and the Medicaid Expansion: No Quick Resolution in Sight*, 368 NEW ENG. J. MED. 496 (2013) (exploring the views of the governors who rejected Medicaid expansion).

49. See, e.g., Antos, *supra* note 47, at 182 (“[S]ometimes any coverage is worse than none.”); Scott Gottlieb, *Medicaid Is Worse Than No Coverage at All*, WALL ST. J. (Mar. 10, 2011, 12:01 AM), <http://online.wsj.com/news/articles/SB10001424052748704758904576188280858303612>; Avik Roy, *Why Medicaid is a Humanitarian Catastrophe*, FORBES (Mar. 2, 2011, 12:23 PM), <http://www.forbes.com/sites/theapothecary/2011/03/02/why-medicaid-is-a-humanitarian-catastrophe/>.

with an entirely different program.<sup>50</sup> The implausible (if not preposterous) argument that people are worse off with Medicaid than with nothing at all rests on a handful of studies reporting that Medicaid patients do worse in some particular medical settings than do uninsured patients.<sup>51</sup> Highly regarded health economist Austin Frakt has thoroughly and convincingly debunked these studies, and this entire line of argument, as follows.<sup>52</sup>

Frakt explains that observational studies that compare uninsured people with those covered by Medicaid are completely inadequate for drawing conclusions about whether Medicaid coverage causes worse health.<sup>53</sup> This is because people do not sort themselves randomly between insurance conditions.<sup>54</sup> All else being equal, sick people are more likely to seek out insurance, including Medicaid.<sup>55</sup> As a result, uninsured people are, in general, substantially healthier than people with Medicaid.<sup>56</sup> Therefore, it is almost certainly spurious to conclude that Medicaid is the cause of the worse health observed in those whom it covers.

By contrast, studies that either randomly assign people between different insurance conditions or studies that carefully measure how a person's health changes once they enroll in Medicaid are much more reliable.<sup>57</sup> These types of studies convincingly establish substantial

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50. See Roy, *supra* note 49. Governor Rick Perry of Texas, for instance, expounded that adding uninsured people to Medicaid is "not unlike adding a thousand people to the Titanic." Sommers & Epstein, *supra* note 48, at 498.

51. See, e.g., Michael A. Gaglia et al., *Effect of Insurance Type on Adverse Cardiac Events After Percutaneous Coronary Intervention*, 107 AM. J. CARDIOLOGY 675, 679 (2011) (finding that "both government-sponsored insurance and no insurance, in comparison to private insurance, were associated with more adverse cardiac events").

52. See Austin Frakt et al., *Our Flawed but Beneficial Medicaid Program*, 364 NEW ENG. J. MED. e31(1), e31(2) (2011), available at <http://www.nejm.org/doi/pdf/10.1056/NEJMp1103168>; Austin B. Frakt & Aaron E. Carroll, *Sound Policy Trumps Politics: States Should Expand Medicaid*, 38 J. HEALTH POL. POL'Y & L. 165, 168 (2013).

53. Frakt et al., *supra* note 52, at e31(2).

54. See *id.*

55. See *id.* (recognizing that social workers may help the sickest or neediest patients enroll in Medicaid and that this emphasis on helping those in need creates selection bias that confounds observational studies).

56. See John Holahan, *Health Status and the Cost of Expanding Insurance Coverage*, 20 HEALTH AFF. 279, 279-80 (2001).

57. See Heidi Allen et al., *The Oregon Health Insurance Experiment: When Limited Policy Resources Provide Research Opportunities*, 38 J. HEALTH POL. POL'Y & L. 1183, 1189-90 (2013) (explaining that random assignment ensures that researchers can reasonably attribute differences in subsequent outcomes to changes in insurance coverage "rather than differences in baseline health, income, social capital, or any other explanation").

health benefits from Medicaid coverage.<sup>58</sup> The most convincing study design—a randomized controlled experiment—is rarely done in major social circumstances because people are reluctant to allow important life decisions like health insurance to be made by chance.<sup>59</sup> Moreover, it is expensive to design a study that pays for peoples' insurance. The only major randomized study of health insurance ever done was conducted in the late 1970s<sup>60</sup> and so it has diminished relevance to many modern programs.

By good fortune (for researchers), however, Oregon recently implemented an earlier expansion of its Medicaid program in a manner that produced a natural randomized trial.<sup>61</sup> Lacking the funds to enroll everyone who was eligible, it assigned 90,000 people by lottery to 10,000 available enrollment slots.<sup>62</sup> This presented Harvard researchers with a golden opportunity to track how Medicaid patients' health changed after enrollment, compared to a virtually identical group that remained uninsured. The Oregon study is still in its early phases and so conclusive results are not yet available. After two years, substantial health improvements have not been documented through medical tests such as blood pressure and cholesterol levels.<sup>63</sup> However, initial results show that Medicaid enrollees "are 25% more likely to indicate that they're in good, very good, or excellent health (vs. fair or poor health)" after only one year of enrollment.<sup>64</sup> Self-reported health is not the gold standard of actual health, but it is a measure of health that has been well validated and is used widely in medical and health policy studies.<sup>65</sup>

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58. See JULIA PARADISE & RACHEL GARFIELD, KAISER COMM'N ON MEDICAID & THE UNINSURED, WHAT IS MEDICAID'S IMPACT ON ACCESS TO CARE, HEALTH OUTCOMES, AND QUALITY OF CARE? (2013), available at <http://kff.org/medicaid/issue-brief/what-is-medicaid's-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence/> (collecting evidence of effectiveness in the Medicaid program, including improved measures of health).

59. In one researcher's estimation, there had been only three randomized evaluations of health insurance in the United States as of December 2013. See Allen et al., *supra* note 57, at 1189.

60. See JOSEPH P. NEWHOUSE ET AL., FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT 4-5 (1993); RAND's *Health Insurance Experiment*, RAND CORP., <http://www.rand.org/health/projects/hie.html> (last visited May 5, 2014).

61. See Allen et al., *supra* note 57, at 1183-84.

62. See Katherine Baicker & Amy Finkelstein, *The Effects of Medicaid Coverage—Learning from the Oregon Experiment*, 365 NEW ENG. J. MED. 683, 684 (2011).

63. See Katherine Baicker et al., *The Oregon Experiment—Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713, 1719 (2013).

64. See Baicker & Finkelstein, *supra* note 62, at 684.

65. See, e.g., Stephen Joel Coons et al., *A Comparative Review of Generic Quality-of-Life Instruments*, 17 PHARMACOECONOMIC 13, 16-18 (2000); John McSweeney & Thomas

Another recent well-designed study is one that measured changes in mortality following Medicaid expansion in three states (New York, Maine, and Arizona), comparing those changes to four matched neighboring states that are similar but did not expand Medicaid (Pennsylvania, New Hampshire, and Nevada/New Mexico).<sup>66</sup> This study employed a powerful differences-in-differences analysis, which looks specifically at how the *change* in the mortality rate (rather than the absolute level of mortality) compares between states with and without a Medicaid expansion.<sup>67</sup> These Harvard researchers (whose work is published in the *New England Journal of Medicine*) found that Medicaid expansions “were associated with a significant reduction in . . . mortality.”<sup>68</sup> Extrapolating these and other findings, another group of Harvard researchers calculated that states not expanding Medicaid may experience anywhere from 7,000 to 17,000 more deaths per year.<sup>69</sup>

Lacking any solid evidence for the claim of Medicaid’s inferiority, some opponents shift their rhetorical tactics to argue that Medicaid does not work as well as it could. They point to various problems in Medicaid and then argue that it should not be further expanded until it is improved.<sup>70</sup> North Carolina Governor Pat McCrory, for instance, declared that “the current [Medicaid] system in North Carolina is broken and not ready to expand without great risk to the taxpayers and to the delivery of existing services to those in need. We must first fix and reform the current system” before expanding it.<sup>71</sup>

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Creer, *Health-Related Quality-of-Life Assessment in Medical Care*, 41 DISEASE MONTHLY 6, 45–47 (1995).

66. See Benjamin D. Sommers et al., *Mortality and Access to Care Among Adults After State Medicaid Expansions*, 367 NEW ENG. J. MED. 1025, 1025 (2012).

67. *Id.* at 1027. Comparing trends in mortality, both before and after a policy change and in states with and without the change, is more powerful than simply observing mortality rates in states with and without the policy. Other factors might cause states to differ in the absolute level of mortality, but observing only changes in mortality negates much of these hidden confounding factors. See EUROPEAN COMM’N, EVALUED SOURCEBOOK: METHOD AND TECHNIQUES 78–85 (2013), available at [http://ec.europa.eu/regional\\_policy/sources/docgener/evaluation/guide/evaluation\\_sourcebook.pdf](http://ec.europa.eu/regional_policy/sources/docgener/evaluation/guide/evaluation_sourcebook.pdf).

68. Sommers et al., *supra* note 66, at 1025.

69. See Sam Dickman, David Himmelstein, Danny McCormick & Steffie Woolhandler, *Opting Out Of Medicaid Expansion: The Health and Financial Impacts*, HEALTH AFF. BLOG exhibit 3 (Jan. 30, 2014), <http://healthaffairs.org/blog/2014/01/30/optiming-out-of-medicaid-expansion-the-health-and-financial-impacts/>.

70. See, e.g., Sommers & Epstein, *supra* note 48, at 498 (noting that 38% of the governors opposing Medicaid expansion relied on the “Medicaid is a ‘broken program,’ harms its beneficiaries” theme in explaining their opposition).

71. Mary Cornatzer, *McCrory Says State Not Ready for Medicaid Expansion*, NEWS & OBSERVER (Raleigh) (Feb. 12, 2013), <http://www.newsobserver.com/2013/02/12/2673891>

Even this moderated position lacks solid logic and factual foundation. There are two obvious problems. First, parroting the conservative mantra that “Medicaid is broken and must be fixed before expanding” ignores ample evidence that Medicaid works remarkably well, considering its state of chronic underfunding.<sup>72</sup> For instance, Governor McCrory’s sweeping indictment of North Carolina’s Medicaid program completely ignores the fact that one component of North Carolina Medicaid, known as Community Care of North Carolina (“CCNC”), is one of the most celebrated programs in the country for coordinating care for Medicaid patients.<sup>73</sup> Ironically, the very day that Governor McCrory was insisting that the state refuse any Medicaid expansion until it establishes statewide care coordination, U.S. Senator Richard Burr of North Carolina gave CCNC an award from the national Healthcare Leadership Council to recognize its “quality and efficiency in serving the state’s Medicaid population and particularly the high quality of care it delivers to patients in rural areas.”<sup>74</sup>

Second, insisting that Medicaid improve before expanding commits the “nirvana fallacy” of refusing halfway measures by imagining that there is a much better, but unachievable, level of performance possible. Obviously, Medicaid, like any real-world human enterprise, is flawed in various ways and could be improved. But, these imperfections can hardly be a coherent reason to refuse an influx of additional federal funding. Whatever problems Medicaid has, they are ones that more funding most likely can help to

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/mccrory-says-state-not-ready-for.html. The governor later called for a system of “comprehensive care entities” to be established statewide to coordinate care for Medicaid patients. See Matthew Burns & Bruce Mildworf, *McCrory: Medicaid Needs to Serve Whole Patient*, WRAL.COM (Apr. 3, 2013), <http://www.wral.com/mccrory-medicaid-needs-to-serve-whole-patient/12298883/>.

72. See KAISER COMM’N ON MEDICAID & THE UNINSURED, *supra* note 21, at 20–23; PARADISE & GARFIELD, *supra* note 58, at 4.

73. See, e.g., KAISER COMM’N ON MEDICAID & THE UNINSURED, COMMUNITY CARE OF NORTH CAROLINA: PUTTING HEALTH REFORM IDEAS INTO PRACTICE IN MEDICAID 1 (2009), available at <http://kff.org/health-reform/issue-brief/community-care-of-north-carolina-putting-health/> (recognizing that CCNC put the ideal of a “medical home” for Medicaid enrollees into practice); Thomas C. Ricketts III & Christine Nielsen, *Policy Forum: Community Care of North Carolina*, 70 N.C. MED. J. 217, 218 (2009) (explaining that the North Carolina program is held up as a model); Doug Trapp, *Medical Homes for Medicaid: The North Carolina Model*, AM. MED. NEWS (June 20, 2011), [http://www.amednews.com/article/2010\\_0802/government/308029947/4/](http://www.amednews.com/article/2010_0802/government/308029947/4/) (emphasizing that CCNC is one of the oldest and largest Medicaid medical home programs in the nation).

74. Sarah Ovaska, *Burr in NC to Praise Medicaid Program That Gov. McCrory May Dump*, PROGRESSIVE PULSE (Apr. 3, 2013), <http://pulse.ncpolicywatch.org/2013/04/03/burr-in-nc-praising-medicaid-program-that-gov-mccrory-wants-to-reform/>.

improve—especially compared to the status quo of being uninsured. Even if problems remain, failure to improve is no reason to deny sick and suffering people the benefits that even unimproved Medicaid has to offer.

Certainly, Medicaid—like the rest of American medicine—has substantial room for improvement. However, it is entirely unconvincing to seize on its inevitable limitations to refuse extending Medicaid to people who desperately need access to medical care. Therefore, it is difficult to believe that the quality of Medicaid is any more than a makeweight argument by expansion opponents. Instead, their strongest ammunition is the expressed concern over the costs of expansion.

## II. HOW MUCH (IF ANYTHING) WILL MEDICAID EXPANSION COST STATES?

There are two distinct economic arguments, which this Part considers in turn: first, that the ACA's Medicaid expansion is a bad deal for states at the outset, and second, that even if the ACA's initial terms are favorable, there is a significant risk of "bait and switch" by the federal government, leaving states to pay a greater share of expansion costs in the future.

### A. *The Financial Costs and Benefits of Expansion*

There is at least surface coherence to the objection that, while Medicaid expansion might be desirable, states simply cannot afford their share of the costs. Paying only ten cents on the expansion dollar may be an excellent deal, but a 90% discount is not free, and refusing states claim they simply lack the funds to pay even their small share of the costs.<sup>75</sup> Moreover, they argue that the actual costs far exceed their 10% portion,<sup>76</sup> pointing to estimates that the ACA will cost states more than \$100 billion over the first ten years of Medicaid expansion.<sup>77</sup>

These estimates are blatantly overstated, however. They are both over-inclusive of the true cost increases and under-inclusive of the

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75. See, e.g., Antos, *supra* note 47, at 180.

76. See S. FIN. COMM. AND H. ENERGY & COMMERCE COMM., 112TH CONG., MEDICAID EXPANSION IN THE NEW HEALTH LAW: COSTS TO THE STATES 2 (Comm. Print 2011), available at <http://energycommerce.house.gov/press-release/medicaid-expansion-health-law-cost-states-118-billion-through-2023>.

77. *Id.* This committee report arrived at the \$100 billion cost by adding together all of the states' estimates of their expansion costs from fiscal year 2014 through fiscal year 2019. See *id.* at 2 n.9.

true savings to expanding states.<sup>78</sup> Some of these projections include all increased Medicaid enrollment, both under states' existing programs and under the ACA's eligibility expansion.<sup>79</sup> Increases under existing programs are known as the "woodwork effect," meaning that people who are currently eligible but not enrolled will sign up because of outreach efforts under the new law.<sup>80</sup> This woodwork effect will occur regardless of whether states expand Medicaid, as the result of screening people for eligibility under the new insurance exchanges. Therefore, any cost associated with the woodwork effect should not be considered in estimating the cost of an expansion or savings from not expanding.

When considering just the expansion population, another flaw in overinflated cost estimates is the assumption about how many of the newly eligible people will actually enroll. As just noted, a good percentage of people eligible for Medicaid do not actually enroll, for reasons such as inconvenience, lack of knowledge, and lack of motivation.<sup>81</sup> Even though enrollment efforts will increase Medicaid uptake, enrollment will still fall significantly short of all those who become eligible.<sup>82</sup> Yet, some inflated estimates assume wildly unrealistic enrollment—sometimes as high as 100%.<sup>83</sup> Poorly done expansion estimates also wrongly assume that new enrollees will incur the same costs as those currently enrolled.<sup>84</sup> Instead, they are likely healthier, and therefore less costly, than current enrollees.<sup>85</sup>

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78. See generally FAMILIES USA, A FAIR ACCOUNTING OF STATE COSTS FOR THE MEDICAID EXPANSION (2013), available at <http://familiesusa2.org/assets/pdfs/medicaid-expansion/State-Costs.pdf> (identifying factors analysts must consider when assessing a state's costs of expanding Medicaid, such as recording the administrative costs incurred whether the state expands Medicaid or not and the potential savings that expansion can provide).

79. See STAN DORN ET AL., URBAN INST., MEDICAID EXPANSION UNDER THE ACA: HOW STATES ANALYZE THE FISCAL AND ECONOMIC TRADE-OFFS 4 (2013), available at <http://www.urban.org/UploadedPDF/412840-Medicaid-Expansion-Under-the-ACA.pdf>.

80. See *id.*

81. See KAISER COMM'N ON MEDICAID & THE UNINSURED, KEY LESSONS FROM MEDICAID AND CHIP FOR OUTREACH AND ENROLLMENT UNDER THE AFFORDABLE CARE ACT 3–4 (2013), available at <http://kff.org/medicaid/issue-brief/key-lessons-from-medicaid-and-chip-for-outreach-and-enrollment-under-the-affordable-care-act/>.

82. See BUETTGENS & HALL, *supra* note 16, at 5–6.

83. See DORN ET AL., *supra* note 79, at 3.

84. *Id.*

85. See Tammy Chang & Matthew Davis, *Potential Adult Medicaid Beneficiaries Under the Patient Protection and Affordable Care Act Compared with Current Adult Medicaid Beneficiaries*, 11 ANN. FAM. MED. 406, 408 (2013).

Opponents also overestimate states' costs by neglecting, or greatly diminishing, entire categories of substantial savings that accrue to states from expanding Medicaid. First, people currently uninsured do not go entirely without care.<sup>86</sup> Instead, they receive some treatment from various safety-net programs and providers—such as emergency rooms and public hospitals or clinics—that states and municipalities partially fund.<sup>87</sup> Increased Medicaid enrollment will diminish these current state and local expenditures for the uninsured. The same is also true for the significant amounts that states currently spend to treat prisoners, the mentally ill, and people in a variety of special programs administered by county health departments.<sup>88</sup>

Taking all of these factors into consideration, the most rigorous analyses conclude that Medicaid expansion is a net financial benefit—or at worst only a very small cost—to state budgets. A nationwide analysis done by the Urban Institute (an independent think tank), using its sophisticated micro-simulation model, estimated that states overall “would save \$3.8 billion in 2016 if all expanded Medicaid.”<sup>89</sup> Because the federal contribution diminishes 10% over the first five years, this analysis reports that Medicaid expansion would eventually cost states something, but the total is a remarkably modest \$8.2 billion nationwide over ten years.<sup>90</sup> Considering that Medicaid expansion would cover more than 10 million additional people,<sup>91</sup> this equates to an annual state cost of less than \$100 per person covered.

Even this minor cost is overstated, since the Urban Institute analysis considers only some of the potential savings to states from expanding Medicaid. For instance, the data sources for their analytical model do not permit precise calculation of states' savings on reduced uncompensated care for the uninsured.<sup>92</sup> However, based on reasonable and conservative estimates by these same analysts, Medicaid expansion would save states \$18.3 billion over the first six

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86. See Mitchell H. Katz, Commentary, *Future of the Safety Net under Health Reform*, 304 JAMA 679, 679 (2010) (discussing the current “safety-net system” in place to provide health care for the uninsured).

87. *Id.*

88. See MATTHEW BUETTGENS ET AL., URBAN INST., CONSIDER SAVINGS AS WELL AS COSTS: STATE GOVERNMENTS WOULD SPEND AT LEAST \$90 BILLION LESS WITH THE ACA THAN WITHOUT IT FROM 2014 TO 2019, at 10 (2011), available at <http://www.urban.org/uploadedpdf/412361-consider-savings.pdf>; HOLAHAN ET AL., *supra* note 17, at 15.

89. HOLAHAN ET AL., *supra* note 17, at 9.

90. *Id.*

91. *Id.* at 3.

92. *Id.* at 11.



years of expansion.<sup>93</sup> Subtracting the \$8 billion ten-year cost produces a net state savings of \$10 billion.<sup>94</sup>

The Urban Institute notes that these national estimates still do not consider the full range of savings available to states.<sup>95</sup> For instance, they do not consider a range of state-specific programs whose costs Medicaid expansion would reduce or eliminate, such as public health programs for cancer screening and immunizations, mental health care, medical care for prisoners, and current Medicaid coverage that is more generous than the previous federal minimums.<sup>96</sup> Calculating these savings requires more detailed state-specific analyses, which many states have done, with a variety of methodologies, producing a range of different results.<sup>97</sup> Reviewing these studies from ten states, the Urban Institute concluded that, in “each state where relatively comprehensive analyses of costs and fiscal gains were conducted, the net result showed that, on balance, Medicaid expansion would yield state fiscal advantages.”<sup>98</sup>

An additional factor to consider is the stimulus effect of greatly increased federal Medicaid funding. States welcomed the federal funds offered under the American Recovery and Reinvestment Act of 2009 (“ARRA”)<sup>99</sup> for various public works projects because of the jobs they supported.<sup>100</sup> New jobs have multiplicative benefits for the wider economy in that wage earners and their families purchase goods and services that support additional employment.<sup>101</sup> Not only

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93. *Id.*

94. *Id.*

95. *Id.* at 15.

96. *Id.* at 15–16.

97. See RANDALL R. BOVBJERG ET AL., KAISER COMM’N ON MEDICAID & THE UNINSURED, STATE BUDGETS UNDER FEDERAL HEALTH REFORM: THE EXTENT AND CAUSES OF VARIATIONS IN ESTIMATED IMPACTS, at iii (2011), available at <http://kff.org/health-reform/issue-brief/state-budgets-under-federal-health-reform-the/>. For a description of the methodology used to calculate the costs and savings of expanding Medicaid in North Carolina, see N.C. INST. OF MED., EXAMINING THE IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT IN NORTH CAROLINA 78–86 (2013), available at [http://lgdata.s3-website-us-east-1.amazonaws.com/docs/3166/816120/Uninsured\\_FULL-REPORT-2-13-2013.pdf](http://lgdata.s3-website-us-east-1.amazonaws.com/docs/3166/816120/Uninsured_FULL-REPORT-2-13-2013.pdf). The North Carolina Institute of Medicine found that expanding Medicaid would save the state \$65 million over eight years and would cover about 500,000 people. *Id.* at 84 tbl.3.3.

98. DORN ET AL., *supra* note 79, at 7.

99. American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115.

100. See Gabriel Chodorow-Reich et al., *Does State Fiscal Relief During Recessions Increase Employment? Evidence from the American Recovery and Reinvestment Act*, 4 AM. ECON. J.: ECON. POL., no. 3, 2012, at 118.

101. For a basic explanation of the multiplier effect and information about the types of projects funded under the ARRA, see *Has the Stimulus Package Worked?*, CBS NEWS

does such economic stimulus provide social benefit in its own right, economic stimulus generates additional state and local tax revenue and reduces economic and social burdens that state programs must otherwise relieve.<sup>102</sup> These economic benefits flow not only from earmarked “stimulus” funding, but also from other sources of federal spending, such as military funding, or the funds that would flow via Medicaid to hospitals, clinics, therapists, and other health service providers.<sup>103</sup> Medicaid funding creates or supports jobs that not only fuel growth in tax revenues; these jobs create economic opportunities that help to keep people off of Medicaid in the first place.

Estimating these macroeconomic benefits for states is a complex enterprise that requires modeling many interacting variables across a social economy. Despite the inherent uncertainty, this macroeconomic modeling can be and has been done with a good degree of credibility. An analysis for North Carolina, for instance, prepared by a firm that specializes in economic modeling for a wide variety of government programs and projects throughout the country, estimated that the roughly 23,000 jobs Medicaid expansion would create in North Carolina would generate about \$1 billion a year in personal income and \$2 billion a year in increased economic output for the state.<sup>104</sup> Based on conservative estimates of tax implications, this economic stimulus would generate roughly \$70 million of increased state revenue each year.<sup>105</sup> A variety of other analysts have made similar projections in different states.<sup>106</sup> The overriding conclusion from this body of data is that states lack any economic justification for refusing to expand Medicaid; instead, they have strong economic reasons to expand.

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(Sept. 17, 2009, 12:11 PM), <http://www.cbsnews.com/news/has-the-stimulus-package-worked/>.

102. See KAISER COMM’N ON MEDICAID & THE UNINSURED, THE ROLE OF MEDICAID IN STATE ECONOMIES: A LOOK AT THE RESEARCH 1 (2009), available at <http://kff.org/medicaid/issue-brief/the-role-of-medicaid-in-state-economies/> (stating that Medicaid supports “tens of thousands of health care providers throughout the country, including hospitals, nursing facilities, group homes, community health centers and managed care plans”).

103. See *id.* (demonstrating how Medicaid dollars flow through a state’s economy).

104. See SCOTT NYSTROM, REG’L ECON. MODELS, INC., A CONTRAST: MODELING THE MACROECONOMIC IMPACT OF “MEDICAID EXPANSION” IN NORTH CAROLINA 10–13 (2013), available at <http://www.nciom.org/wp-content/uploads/2013/01/Final-App-D-REMI-North-Carolina-Medicaid-Report-1-7-13-FINAL.pdf>.

105. *Id.* at 15.

106. See, e.g., DORN ET AL., *supra* note 79, at 11.

*B. Can Expanding States Back Out Later?*

A final reason states give for refusing federal largesse is not trusting the federal government to keep its commitments to states. Even states that might very much welcome the economic benefits of Medicaid expansion at the outset claim that they worry that the federal government will renege on the deal.<sup>107</sup> Although the ACA has no sunset for its federal support of Medicaid expansion, nothing prevents Congress from changing the ACA's terms in the future. Doubters question whether Congress can afford to continue to pay for Medicaid at this initial level, and so they argue that states will have to foot more or most of the bill once Congress reduces its support.<sup>108</sup>

In theory, only the passage of time can prove these skeptics wrong about lack of congressional fortitude. Nevertheless, this "bait and switch" concern lacks sincerity. First, there is no objective basis to think that the federal government will change the ACA's financial commitment to the states—at least any time soon. Congress has never done so with Medicaid before.<sup>109</sup> Doing so now would obviously produce a firestorm of controversy. Moreover, states can reverse their expansion decision any time they like,<sup>110</sup> so they can simply scale back if Congress ever changed the terms of Medicaid expansion.

Expansion opponents respond that scaling back is not humane or politically feasible once people become accustomed to more generous Medicaid.<sup>111</sup> But states that were willing to forgo the ACA's benefits for their low-income citizens in the first place likely would have little compunction about scaling back the expansion later, if the federal funding terms were to change. The Medicaid program has always given states broad discretion over many of its eligibility, payment, and coverage terms.<sup>112</sup> Every year, states wrestle with how to balance the

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107. See Sommers & Epstein, *supra* note 48, at 498.

108. See Antos, *supra* note 47, at 182.

109. See KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID FINANCING: AN OVERVIEW OF THE FEDERAL MEDICAID MATCHING RATE (FMAP) 2 (2012), available at <http://kff.org/health-reform/issue-brief/medicaid-financing-an-overview-of-the-federal/>.

110. See CTRS. FOR MEDICARE & MEDICAID SERVS., FREQUENTLY ASKED QUESTIONS ON EXCHANGES, MARKET REFORMS, AND MEDICAID 11 (2012), available at <http://www.medicaid.gov/federal-policy-guidance/downloads/FAQ-12-10-2012-Exchanges.pdf>.

111. See Bobby Jindal, Editorial, *Why I Opposed Medicaid Expansion*, TIMES-PICAYUNE (New Orleans) (July 23, 2013, 11:40 AM), [http://www.nola.com/opinions/index.ssf/2013/07/gov\\_bobby\\_jindal\\_why\\_i\\_opposed.html](http://www.nola.com/opinions/index.ssf/2013/07/gov_bobby_jindal_why_i_opposed.html).

112. See CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 110, at 14.

needs of beneficiaries and providers with the constraints of state budgets. These tensions frequently have led states to reduce previously adopted expansions.<sup>113</sup> In short, Medicaid is more of a rollercoaster of eligibility standards than the “roach motel” that critics claim.<sup>114</sup> According to one count, for instance, over the 2002–2005 period “a total of 38 states made restrictions or reductions to Medicaid eligibility in at least one of those four years,”<sup>115</sup> which another source estimates caused over a million people to lose coverage.<sup>116</sup> There is no reason in either principle or practical politics that states cannot do so again in the future.<sup>117</sup>

### CONCLUSION

Considering the patent weaknesses of the stated arguments for not expanding Medicaid, what has convinced conservative lawmakers and policy leaders to purposefully continue the suffering and premature deaths of millions of citizens? The evidence entirely fails to support policy arguments that Medicaid is worse than having no insurance or that expansion would cost states tremendous amounts of

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113. For analysis of how competing factors have pushed state governments to expand and contract Medicaid coverage and eligibility over the past three decades, see Joel C. Cantor et al., *States' Commitment to Medicaid Before the Affordable Care Act*, 50 INQUIRY 71, 73–74 (2013); Teresa A. Coughlin et al., *State Responses to the Medicaid Spending Crisis: 1988 to 1992*, 19 J. HEALTH POL. POL'Y & L. 837, 854 (1994); Thad Kousser, *The Politics of Discretionary Medicaid Spending, 1980–1993*, 27 J. HEALTH POL. POL'Y & L. 639, 647 (2002).

114. Editorial, *New Medicaid's Roach Motel*, WALL ST. J., Mar. 16, 2013, at A12.

115. VERNON SMITH ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, THE CONTINUING MEDICAID BUDGET CHALLENGE: STATE MEDICAID SPENDING GROWTH AND COST CONTAINMENT IN FISCAL YEARS 2004 AND 2005, at 26 (2004), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/the-continuing-medicaid-budget-challenge-state-medicaid-spending-growth-and-cost-containment-in-fiscal-years-2004-and-2005-results-from-a-50-state-survey.pdf>.

116. JUDITH SOLOMON, CTR. ON BUDGET AND POLICY PRIORITIES, REPEALING HEALTH REFORM'S MAINTENANCE OF EFFORT PROVISION COULD CAUSE MILLIONS OF CHILDREN, PARENTS, SENIORS, AND PEOPLE WITH DISABILITIES TO LOSE COVERAGE 1 (2011), available at <http://www.cbpp.org/files/2-10-11health.pdf>.

117. Indeed, states' willingness to scale back Medicaid coverage to meet budget constraints is the reason that Congress included in the ACA a “maintenance of eligibility” provision that required states to avoid any such cutbacks prior to Medicaid expansion taking effect. See KAISER COMM'N ON MEDICAID & THE UNINSURED, UNDERSTANDING THE MEDICAID AND CHIP MAINTENANCE OF ELIGIBILITY REQUIREMENTS 1 (2012), available at <http://kff.org/health-reform/fact-sheet/understanding-the-medicaid-and-chip-maintenance-of/> (explaining that, without this requirement, “more states would have made coverage reductions due to budget pressures”); see also CONG. BUDGET OFFICE, COST ESTIMATE: H.R. 1683 STATE FLEXIBILITY ACT 3 (2011), available at <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12184/hr1683.pdf> (estimating that eliminating this requirement would result in states dropping 400,000 people from Medicaid).

money. Thus, it is difficult to avoid the conclusion that the main motivation for refusing Medicaid expansion is basely political. Opposition to the ACA is an article of political faith among those who oppose President Obama and the Democratic leadership in Congress. Many conservatives have run their federal political races on a pledge to repeal "Obamacare."<sup>118</sup> In addition, refusing Medicaid funds is part of a two-pronged strategy of some conservative leaders to undermine the ACA at the state level<sup>119</sup>—the other being to cede to the federal government the authority to establish insurance exchanges and regulate local insurance markets.<sup>120</sup> Opponents urge these sacrificial tactics because the ACA is President Obama's signature domestic achievement, and so undermining "Obamacare" at any cost is seen as a prime strategy to weaken his political standing.<sup>121</sup> State-level Republicans see political advantage in aligning with these national opposition forces, or they fear the political costs of helping to implement any part of this new national law.<sup>122</sup>

Aside from crass political motivation (that some might think is racially tinged), obstinate ideology is the only other possible justification for the stubborn refusal of federal funds in the face of compelling evidence that Medicaid expansion will cost states little or nothing. Despite the potential to improve health for millions, conservative leaders simply object in principle to accepting more federal funds with any strings attached. As Patrick Henry reminded us, points of principle certainly can be worth dying for, or allowing

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118. See, e.g., Adele Hampton, *Romney Campaign: 'Day One, Job One, Repeal ObamaCare,'* HILL (June 28, 2012, 9:22 PM), <http://thehill.com/video/campaign/235499-romney-campaign-day-one-job-one-repeal-obamacare>.

119. See, e.g., Michael F. Cannon, *Obamacare Is Still Vulnerable*, NAT'L REV. ONLINE (Nov. 9, 2012, 4:00 AM), <http://www.nationalreview.com/articles/333040/obamacare-still-vulnerable-michael-f-cannon>; Veronique de Rugy, *The Next Step: Four Ways to Fight Obamacare*, NAT'L REV. ONLINE (Oct. 21, 2013, 5:33 PM), <http://www.nationalreview.com/corner/361803/next-step-four-ways-fight-obamacare-veronique-de-rugy>; Michael Tanner, *The States Resist Obamacare*, NAT'L REV. ONLINE (July 4, 2012, 12:00 AM), <http://www.nationalreview.com/articles/304729/states-resist-obamacare-michael-tanner>.

120. One purely strategic reason for conservative states to cede this control to the federal government was the legal argument that, due to a glitch in the ACA's drafting, people can qualify for the premium tax subsidy only by enrolling through a state-based exchange and not through the federal fallback exchange. However, a federal court in the District of Columbia rejected this argument, ruling that Congress intended to make premium tax credits available through both state-run and federally facilitated health care exchanges. See *Halbig v. Sebelius*, CV 13-0623, 2014 WL 129023, at \*1, \*18 (D.D.C. Jan. 15, 2014).

121. See Weisman & Stolberg, *supra* note 14.

122. See, e.g., Antos, *supra* note 47, at 180 (speculating that governors who choose to expand Medicaid "stand a good chance of being thrown out of office in the next election").

others to die for, but is state autonomy over Medicaid one such do-or-die principle? If not, spiteful refusal of federal funds in order to undermine the ACA is at least callous, if not reprehensible.

