

---

---

# THE MEDICAID GAMBLE

ANN MARIE MARCIARILLE\*

## I. INTRODUCTION

The Patient Protection and Affordable Care Act (ACA)<sup>1</sup> was an unprecedented gamble. As passed, the ACA transformed Medicaid from an unevenly and underfunded program for the poor and disabled to a program to offer those priced out of commercial insurance markets government-funded health insurance similar to Medicare, the single-payer system for seniors and the disabled. In a sense, the ACA gambled that Medicaid could be more like Medicare.

The ACA, as it was transformed by the Supreme Court of the United States, became a gamble on the part of the Court that good things would follow from empowering each of the states to individually determine the fate of Medicaid expansion in its jurisdiction. Giving states the option to expand has given each of them enormous leverage in their bargaining with the federal executive and legislature over what shape their individual version of this jointly-funded state-federal program will take.

The ACA's Medicaid expansion or non-expansion on the ground, as it is being carried out by the states cooperatively or uncooperatively with the federal government, is likely to be a third thing. The country is likely to see all possibilities happen at once, in different places. In some states, Medicaid is likely to become much more like Medicare. In others, Medicaid may change slowly and incrementally, if at all. And, in others, Medicaid may become more like exchange-mediated commercial insurance.

This article will address what these Medicaid gambles are, how these gambles are likely to resolve themselves, and whether Medicaid as we know it is likely to survive the ACA.

---

Copyright © 2014 by Ann Marie Marciarille.

\* Associate Professor of Law at the University of Missouri-Kansas City School of Law. Thanks to Brad DeLong, Diane Hoffmann, Frank Pasquale, and Ruqaiyah Yearby for assistance in clarifying my thinking on this matter. Thanks to Heather Beer, Marisa Hamm-Malanowski, Abigail McClellan, Leah Miyamoto and Wade Schilling for research assistance and to Tess Hess for her editorial work. This research was funded by a grant from the University of Missouri at Kansas City School of Law. Special thanks to the Blum Center for Developing Economies at the University of California in Berkeley for their provision of summer office and research space.

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of 26 U.S.C.).

The thesis of this article is that when we disagree about Medicaid expansion under the ACA we are disagreeing about the very purpose and history of Medicaid as well as the shape of the program going forward. We are also engaging in an empirical dispute over how much, if any, improvement in health outcomes Medicaid produces or may produce for those enrolled in the program. Finally, we are also participating in a philosophical debate over both what poor people need from American society and what we as a society need from poor people in order to broaden their access to health insurance and health care.

I advance my thesis by discussing the ACA's goals for Medicaid, the partial transformation of these goals by the Supreme Court, and remarkable history of fifty bespoke versions of Medicaid, now only enhanced by the strong use of Medicaid's 1115 waiver process to bring premium supported Medicaid expansion to fruition.<sup>2</sup>

The ACA's Medicaid expansion is polarizing as a result of its historical origins, its multifold purposes, and of empirical conflict over how much improvement in health outcomes Medicaid in fact produces for its beneficiaries.

Five early Medicaid expansion states plus the District of Columbia have placed their big bets on expanding Medicaid to make it more like Medicare.<sup>3</sup> These jurisdictions will have added over 500,000 Americans to the Medicaid even before the broader January 2014 ACA rollout.<sup>4</sup> California, for example, is well on the way to expanding Medi-Cal<sup>5</sup> to cover one out of every four Californians.<sup>6</sup> But is there the will and the money to see the game through? California, for example, is also offering some of the lowest Medicaid provider reimbursement rates in the country.<sup>7</sup> It is thus guaranteeing that its current shortage of Medicaid primary care services providers will likely become even more acute.<sup>8</sup> Medicare's success as a single-payer system is based on its willingness to (so far) offer reimbursement rates that

---

2. See *infra* Parts II–IV (describing issues related to the ACA's purpose with regards to Medicaid, the effects of recent Supreme Court decisions, and the historical and present condition of Medicaid with regards to the fifty states).

3. See *States Getting a Jump Start on Health Reform's Medicaid Expansion*, KAISER FAMILY FOUND. (Apr. 2, 2012), <http://kff.org/health-reform/issue-brief/states-getting-a-jump-start-on-health/> (noting that California, Connecticut, the District of Columbia, Minnesota, New Jersey, and Washington have already taken steps to expand Medicaid to low-income adults).

4. *Id.*

5. Medi-Cal or MediCal is California's version of Medicaid. *Medi-Cal Eligibility and Covered California - Frequently Asked Questions*, CAL. DEP'T OF HEALTH SERVS. (last modified Oct. 17, 2013), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Medi-CalFAQs2014a.aspx#1>.

6. *Id.*; see also LAUREL LUCIA et al., U.C. BERKELEY LABOR CTR. & UCLA CTR. FOR HEALTH POLICY RESEARCH, *MEDI-CAL EXPANSION UNDER THE AFFORDABLE CARE ACT 7* (Jan. 2013), available at [http://laborcenter.berkeley.edu/healthcare/medi-cal\\_expansion13.pdf](http://laborcenter.berkeley.edu/healthcare/medi-cal_expansion13.pdf).

7. See CAL. BUDGET PROJECT, *EXPANDING HORIZONS: KEY FACTS ABOUT THE MEDI-CAL PROGRAM AS CALIFORNIA IMPLEMENTS HEALTH CARE REFORM 7* (2013), available at [http://cbp.org/pdfs/2013/130402\\_Expanding\\_Horizons.pdf](http://cbp.org/pdfs/2013/130402_Expanding_Horizons.pdf) (describing the increase in spending per enrollee and doctor reimbursement rates as among the lowest in the US).

8. See *id.* at 50–51 (showing California to have the second lowest percentage of office-based physicians accepting new Medicaid patients in the country, at 57.1%, compared to the national average of 69.4%).

the overwhelming majority of doctors regard as acceptable.<sup>9</sup> Yet California continues to vociferously litigate its right to lower Medicaid far below Medicare-rate reimbursement in the future.<sup>10</sup> This article considers whether this is consistent with carrying out the original Medicaid expansion goals of the ACA.

As of October 23, 2013, twenty-five states appear poised to begin their Medicaid expansion according to the original legislatively-intended terms of the ACA on January 1, 2014.<sup>11</sup> But twenty-five other states are not. Four of the states that are expanding, led by Arkansas,<sup>12</sup> are attempting right now to strike deals with the Obama administration to make their Medicaid expansion move to exchange-mediated commercial insurance rather than single-payer Medicare.<sup>13</sup> The

---

9. See Dan Diamond, *More Doctors Are Quitting Medicare. Is Obamacare Really to Blame?*, CAL. HEALTHLINE (Aug. 7, 2013), <http://www.californiahealthline.org/road-to-reform/2013/more-doctors-are-quitting-medicare-is-obamacare-really-to-blame> (noting the growing number of physicians accepting Medicare patients and the fact that the program represents a significant percentage of patients for American Academy of Family Physician members).

10. See, e.g., *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204 (2012) (discussing the suit brought by health care providers challenging the reduction in Medicaid reimbursement and California's defense that it has a right to reduce payments).

11. As of this writing, the following states are moving forward with Medicaid expansion at this time: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, the District of Columbia, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Rhode Island, Vermont, Washington, and West Virginia. See *The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand*, KAISER FAMILY FOUND. fig.1 (Oct. 23, 2013), <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/> [hereinafter *The Coverage Gap*]. Of those, Arkansas, Iowa, and Michigan are exploring an approach to expansion likely to require waiver approval. *Id.* Tennessee is also exploring an approach to Medicaid expansion likely to require waiver approval, although it is not moving forward at this time. *Id.* New Hampshire has called a special session to discuss expansion. *Id.* It is also worth noting that state ACA Medicaid expansion or non-expansion is in a constant state of flux. See Nicole Huberfeld, *Federal-State Tensions in Fulfilling the ACA's Promises*, CONST. DAILY (Oct. 6, 2013), <http://blog.constitutioncenter.org/2013/10/federal-state-tensions-in-fulfilling-the-acas-promises/> (noting that "[i]n almost every state reported as 'leaning toward not participating,' and in many states reported as 'not participating,' some significant act has occurred to explore implementation of the Medicaid expansion").

12. As of October 23, 2013, Indiana, Iowa, and Oklahoma were considering following Arkansas's lead to participate in Medicaid expansion through an alternate expansion model. See *id.* Arkansas's model was approved by the federal government. See ROBERT PEAR, *One State's Way to Bolster Health Coverage for the Poor*, N.Y. TIMES, Sep. 27, 2013, [http://www.nytimes.com/news/affordable-care-act/2013/09/27/one-states-way-to-boost-health-coverage-for-poor/?\\_r=0](http://www.nytimes.com/news/affordable-care-act/2013/09/27/one-states-way-to-boost-health-coverage-for-poor/?_r=0) [hereinafter *Bolster Health Coverage for the Poor*]. Likewise, Iowa's plan was granted conditional approval. See *State Market Profiles: Iowa*, KAISER FAMILY FOUND. (Nov. 18, 2013), <http://kff.org/health-reform/state-profile/state-exchange-profiles-iowa/>. Michigan's plan has been submitted for approval. See *Michigan Asks Feds for Medicaid Expansion Approval*, NBC 25 (Nov. 8, 2013), <http://www.minbcnews.com/news/story.aspx?id=969067#Uo-JwfsntI>. Tennessee continues to consider the issue. See RICK LYMAN, *Tennessee Governor Hesitates on Medicaid Expansion, Frustrating Many*, N.Y. TIMES, Nov. 16, 2013, <http://www.nytimes.com/2013/11/17/us/politics/tennessee-governor-hesitates-on-medicaid-expansion-frustrating-many.html>.

13. On September 27, 2013, the Arkansas waiver application popularly referred to as the private option for Medicaid expansion was approved by the federal government. See *Bolster*

remaining states are—for now—turning down the \$5,000 annual payout per additional beneficiary that the federal government is offering, either in the hope that resistance will bring down the ACA, the fear that their state finances will be unable to carry the long-run burden of Medicaid expansion, or in the expectation that holdouts will get better terms as the Obama administration and Democratic legislators find keeping federal commitments low is less urgent than reducing the numbers of the uninsured.

The majority in *National Federation of Independent Business v. Sebelius*, led by Chief Justice Roberts, found the ACA Medicaid expansion as written to be unduly coercive and thus turned what Congress passed and the president signed from one Medicaid gamble into at least four, and perhaps as many as fifty-one gambles.<sup>14</sup>

The first Medicaid gamble was the one the legislative majorities that passed the ACA intended to make: that it would be possible, and a good thing, to make Medicaid more like Medicare.<sup>15</sup> That gamble is going forward in the early-adopter states, including Arizona, Colorado, Maryland, Massachusetts, New Mexico, and Washington.<sup>16</sup> Overlaid on top of it is a second Medicaid gamble: the gamble that states like California are taking, in that Medicaid can be turned into something like Medicare without raising provider reimbursement rates to something like Medicare levels.<sup>17</sup> Additionally, there is a third Medicaid gamble: a gamble that previous Supreme Court worries about federal coercion of states did not raise the possibility that the Court might disallow nationwide Medicaid expansion,<sup>18</sup> and that insurance against such an activist Court should be acquired via a fallback mechanism.

The fourth Medicaid gamble was that of United States Supreme Court Chief Justice John Roberts: that bending the arc of history away from long-run government expansion is best accomplished not by risking the Supreme Court's moral authority via a declaration that the ACA's individual mandate was unconstitutional, but rather by putting the Court's thumb on the scales so that states could bargain with the federal government about how, and when, and if, the ACA

---

*Health Coverage for the Poor*, *supra* note 12 (describing the approved program).

14. See *infra* Part II (describing the series of gambles associated with Medicaid expansion in light of the *National Federation of Independent Business v. Sebelius* decision).

15. See *infra* Part IV.A (describing the push to make Medicaid more like Medicare).

16. See *Status of State Action on the Medicaid Expansion Decision, as of October 22, 2013*, KAISER FAMILY FOUND. (Oct. 22, 2013), <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/> (describing the current status regarding early adoption of Medicaid expansion in the states).

17. See Phil Galewitz, *Few Medicaid Docs Have Seen 2013 Pay Raise*, KAISER HEALTH NEWS (July 16, 2013), <http://capsules.kaiserhealthnews.org/index.php/2013/07/few-medicaid-docs-have-seen-2013-pay-raise/> (detailing how California's reimbursement rates have not risen with the expansion of Medicaid).

18. See MARYBETH MUSUMECI, KAISER FAMILY FOUND., A GUIDE TO THE SUPREME COURT'S DECISION ON THE ACA'S MEDICAID EXPANSION (2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8347.pdf> (showing the complex patchwork of concerns that the Supreme Court had regarding Medicaid expansion).

were to be implemented.<sup>19</sup> The fifth Medicaid gamble was subordinate to the third: the apparent gamble of Justices Kagan and Breyer that a functional judicial rewriting-on-the-fly of the ACA statute would not break the mechanism.<sup>20</sup>

And then there are the various state level Medicaid gambles: Arkansas's and other states' gambles that Medicaid can be made more like commercial insurance without busting their state budgets, or at least that the federal government will hold states harmless if they pursue high-cost Medicaid expansion paths;<sup>21</sup> other states gamble that their hospitals, doctors, and citizens can flourish without Medicaid expansion;<sup>22</sup> and still other states gamble that by delaying Medicaid expansion they can negotiate better terms for themselves—à la Nebraska's "cornhusker kickback"<sup>23</sup>—from the federal government when and if they do expand.<sup>24</sup>

The purpose of this article is to build a framework for understanding the complex evolution of Medicaid going forward.

---

19. See Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S.Ct. 2566, 2608 (2012) (explaining that the Medicaid expansion aspect of the ACA is unconstitutional because it tells the States how to regulate and that Congress can give grants and incentives to gain state acceptance but the State must have a choice in the matter).

20. See *id.* at 2607 (explaining that, despite the characterization of the joint dissent, by withdrawing Medicaid funds from States that do not comply with the ACA's Medicaid expansion, the Court is not rewriting the statute, but simply enforcing the Constitution).

21. See Sarah Kliff, *Arkansas Is Using This Weird Trick To Expand Medicaid*, WASH. POST WONKBLOG (Sept. 27, 2013), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/09/27/arkansas-is-using-this-weird-trick-to-expand-medicaid> (explaining that CMS approved an Arkansas Medicaid expansion plan that allowed qualified recipients to purchase private health insurance, with Medicaid paying the bill); *U.S. Clears Arkansas Medicaid Expansion Proposal*, REUTERS (Sept. 27, 2013, 1:25 PM), <http://www.reuters.com/article/2013/09/27/us-usa-medicaid-arkansas-idUSBRE98Q0WM20130927> (explaining that Iowa and Pennsylvania, like Arkansas, have also been looking for ways to modify Medicaid expansion).

22. See, e.g., *Missouri Senate Panel Rejects Medicaid Expansion*, KANSAS CITY STAR, Nov. 14, 2013, <http://www.kansascity.com/2013/11/14/4620782/missouri-senate-panel-rejects.html> (explaining that a Missouri Senate committee rejected Medicaid expansion because flaws in the current Medicaid system left the committee feeling uneasy about expanding the program).

23. See Jordan Fabian, *Obama Healthcare Plan Nixes Ben Nelson's 'Cornhusker Kickback' Deal*, THE HILL (Feb. 22, 2010, 3:00 PM), <http://thehill.com/blogs/blog-briefing-room/news/82621-obama-healthcare-plan-nixes-ben-nelsons-cornhusker-kickback-deal> (explaining that an earlier version of the ACA included one hundred million dollars in Medicaid funding earmarked for Nebraska to win Nebraska Senator Nelson's support for the ACA, an earmark which was ultimately excluded from the legislation).

24. See J. Lester Feder & Jason Millman, *Medicaid Ruling Could Give Red States More Bargaining Power*, POLITICO (June 29, 2012, 5:08 PM), <http://www.politico.com/news/stories/0612/78040.html> (explaining that despite being able to opt out of Medicaid expansion, many states will not, knowing that they can use President Obama's desire to have all states participating to their advantage in getting concessions from the government in exchange for their cooperation).

## II. THE ACA'S MEDICAID GAMBLES

In the aftermath of the *National Federation of Independent Business v. Sebelius* holding,<sup>25</sup> legal scholars and policymakers focused their attention on the Supreme Court's decision that the individual mandate provisions and accompanying insurance market reforms could survive as a tax.<sup>26</sup> Less attention was paid to the Supreme Court's bold decision to rein in the authority of the Secretary of the Department of Health and Human Services (the Secretary) to enforce the states' compliance with the amended Medicaid statute by conditioning receipt of any federal funds for Medicaid on state participation in the amended Medicaid program. Yet that bold decision may well, in retrospect, be seen as the most important part of the *National Federation* decision, for it was what turned what had been one single Medicaid Gamble into many.

*A. The ACA's Original Medicaid Gamble: Making the ACA More Like Medicare*

The intent of the legislative majorities that passed the ACA was to undertake a gigantic Medicaid Gamble.<sup>27</sup> They gambled that Medicaid could be transformed from an unevenly funded and underfunded program for the poor and disabled, to a program offering those priced out of commercial insurance markets government-funded health insurance similar to Medicare, the single-payer system for seniors and the disabled.<sup>28</sup>

---

25. See Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2608 (2012) (holding that the individual mandate, while not a valid exercise of the Commerce Clause, is within Congress' taxing power).

26. See David B. Rivkin, Jr. et al., NFIB v. Sebelius and the Triumph of Fig-Leaf Federalism, CATO SUP. CT. REV. 31, 45–56 (2012) (exploring counter-arguments to the Court's holding that the individual mandate could be upheld as a tax); see also Timothy Jost, *The Supreme Court On The Individual Mandate's Constitutionality: An Overview*, HEALTH AFF. BLOG (June 28, 2012, 2:36 PM), <http://healthaffairs.org/blog/2012/06/28/the-supreme-court-on-the-individual-mandates-constitutionality-an-overview> (explaining that past courts rejected the tax argument, but that the government kept pressing it and the tax argument ultimately won favor in the Court).

27. See Robert Pear & David M. Herszenhorn, *Finance Panel Wraps Up Its Work on Health Care Bill*, N.Y. TIMES, Oct. 3, 2009, at A16 (explaining that lawmakers in Washington, D.C. hope that the cost of Medicaid expansion will not exceed \$900 billion over ten years because, if it does, Senator Max Baucus notes that “we have got a problem.”).

28. See Diane Rowland & Barbara Lyons, *Medicare, Medicaid, and the Elderly Poor*, 18 HEALTH CARE FIN. REV. 61, 61, 65 (1996) (explaining that Medicaid complements Medicare in assisting low-income Medicare beneficiaries pay their Medicare premiums and that the large volume of poor “relying solely on Medicare for coverage underscores the limits of Medicaid's reach.”); Robert J. Master & Carol Taniguchi, *Medicare, Medicaid, and People With Disability*, HEALTH CARE FIN. REV. 91, 96 (1996) (explaining that from the early stages of the program, Medicaid has been essential to providing people with disabilities access to health services); Juliette Forstenzer Espinosa, *Reimagining Federal and State Roles for Health Reform Under the Patient Protection and Affordable Care Act*, ACADEMY HEALTH 4 (2010), [http://www.academyhealth.org/files/publications/ResInsights\\_ReformRoles.pdf](http://www.academyhealth.org/files/publications/ResInsights_ReformRoles.pdf) (explaining that under the ACA states are required to create health insurance exchanges, which give an opportunity to those with little to no consumer insurance choices the ability to obtain higher coverage at lower prices).

*B. The Absence of Fallback Mechanisms*

The ACA's drafters included a fallback provision in case of state non-acceptance of the federal invitation to set up state-based health exchanges,<sup>29</sup> but there are no fallback provisions for the Medicaid expansion. The fallback for exchanges is that there will be a federally-facilitated exchange for each non-exchange-building state.<sup>30</sup> In retrospect, the failure to include an equivalent fallback provision for the Medicaid expansion was yet another tremendous Medicaid gamble. The lack of a fallback option for Medicaid expansion contributes to our current impasse, as any state that prefers not to be all in on Medicaid expansion as outlined in the ACA must find its own way through the cumbersome 1115 process<sup>31</sup> to broker a compromise, losing precious federal Medicaid super-match dollars as well as expanded coverage for its citizens in the interim.<sup>32</sup>

The Supreme Court's holding in *National Federation*, that Congress could not force the states to extend Medicaid coverage under the ACA as a pre-condition for funding continuing Medicaid participation, was yet a third immense Medicaid gamble.<sup>33</sup> As Justice Ginsburg noted, Congress could have repealed the Medicaid Act entirely, replaced it with a new, renamed program identical in substance to the Medicaid statute as amended by the ACA, and left the states free to join or not.<sup>34</sup> Because Congress did not do that, the Court held that it was unduly coercive for Congress to condition funding for the entire program on compliance with the ACA's Medicaid expansion.<sup>35</sup> The Court thus created a core program that might be

29. See 42 U.S.C. § 18041(c) (2006 & Supp. V 2012) (providing action to be taken if a State either is not an electing State, or if the Secretary determines that the required exchange will not be operational by January 1, 2014, or if the State hasn't taken other actions necessary to meet the standards set out in the ACA).

30. See *id.* (providing that if a State fails to establish the required exchange, the Secretary will establish and operate such an exchange within the State).

31. See *Five Key Questions and Answers About Section 1115 Medicaid Demonstration Waivers*, KAISER FAMILY FOUND. 3 (June 2011), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8196.pdf> [hereinafter *Five Key Questions and Answers*] (explaining the process for getting a Section 1115 waiver approved, including discussions which take place before even having an application, obtaining an application for a waiver, CMS reviewing the waiver, notice and comment procedures, and then significant negotiation between states and HHS to get the waiver approved, with timelines varying significantly for this process).

32. See Ed Kilgore, *New Republic: Court Curtails Medicaid Expansion*, NAT'L PUB. RADIO (June 29, 2012, 9:20 AM), <http://www.npr.org/2012/06/29/155974499/new-republic-court-curtails-medicaid-expansion> (describing the federal money being offered in Medicaid expansion as a "super-match"); see also *Five Key Questions and Answers*, *supra* note 31 (explaining that the length of time it takes to get approval for a 1115 waiver varies significantly).

33. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2607 (2012) ("[w]hat Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding").

34. See *id.* at 2629 (Ginsburg, J., concurring) ("Congress could have recalled the existing legislation, and replaced it with a new law making Medicaid as embrace of the poor as Congress chose.").

35. See *id.* at 2604–05 (majority opinion) (explaining that conditioning Medicaid funding on

described as “pre-ACA Medicaid”. Pre-ACA Medicaid bears very little resemblance to the original iteration of Medicaid.<sup>36</sup> The Court thus created an optional secondary extender, henceforth labeled “ACA Medicaid Expansion”. The Court gave each state the option to decide whether to continue to participate in the former program of pre-ACA Medicaid and, separately, whether to participate in the latter program of the ACA Medicaid expansion.<sup>37</sup>

### C. *A Word About Exchanges*

As of July 2013, sixteen states and the District of Columbia intend to operate state exchanges.<sup>38</sup> Twenty-seven will have federally facilitated exchanges<sup>39</sup> as of January 1, 2014.<sup>40</sup> Seven states chose hybrid models,<sup>41</sup> leaving the federal government—in whole or in part—responsible for the establishment and operation of thirty-four exchanges on January 1, 2014.<sup>42</sup> This is far more active a role in the exchanges than the federal government contemplated playing.<sup>43</sup>

The implications of the federal government operating federally facilitated exchanges under an insurance purchasing scheme designed for state-guided entry into the state-regulated insurance marketplace adds layers of complexity and political sensitivity to the task.<sup>44</sup> The challenges, in short, are operational and

---

acceptance of ACA Medicaid expansion is “a gun to the head” and “economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion.”).

36. See LAURA KATZ OLSON, *THE POLITICS OF MEDICAID* 26, 74–75 (2010).

37. See *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. at 2608 (“States may now choose to reject the expansion... [o]ther States, however, may voluntarily sign up, finding the idea of expanding Medicaid coverage attractive”).

38. Tracy Garber & Sara Collins, *Update: State Action Round-Up on Affordable Care Act Implementation*, COMMONWEALTH FUND BLOG (July 19, 2013), <http://www.commonwealthfund.org/Blog/2013/Jul/State-Action-Roundup-July-19.aspx>.

39. *Id.*; see also BERNADETTE FERNANDEZ & ANNIE L. MACH, CONG. RESEARCH SERV., R42663, *HEALTH INSURANCE EXCHANGES UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) 10* (2013) (defining a federally facilitated exchange as one in which the Department of Health and Human Services (HHS) controls and carries out all functions of the exchange).

40. *Status of Health Insurance Exchange Implementation*, CTR. ON BUDGET & POLICY 2, <http://www.cbpp.org/files/CBPP-Analysis-on-the-Status-of-State-Exchange-Implementation.pdf> (last visited Feb. 19, 2014).

41. See FERNANDEZ & MACH, *supra* note 39, at 10 (defining a hybrid model as a “partnership” that combines state-designed and operated functions with federally designed and operated function, however HHS retains authority over these exchanges).

42. *Id.*

43. 155 CONG. REC. S13558–06, (daily ed. Dec. 20, 2009) (Statement of Senator Max Baucus entering into the record, The O’Neill Institute, *LEGAL SOLUTIONS IN HEALTH REFORM—THE CONSTITUTIONALITY OF MANDATES TO PURCHASE HEALTH INSURANCE*) (discussing the role of the States in the exchanges).

44. See Sarah Goodell, *Health Policy Brief: Federally Facilitated Exchanges*, HEALTH AFF. 3 (Jan. 31, 2013), [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=84](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=84) (arguing that by allowing states oversight responsibilities, the federal government will have to be cognizant of the variety of state laws and regulations in a addition to the new federal regulations).

regulatory, as well as political.<sup>45</sup> The Department of Health and Human Services (HHS) indicated, for example, that it will rely on state-conducted premium rate reviews and network adequacy determinations as part of the health plan certification process in federally facilitated exchanges.<sup>46</sup> The federal government, from one perspective, serves as the handmaiden of the non-expansion state by building its exchange on state-specific data and standards.<sup>47</sup> States, which have traditionally regulated insurance,<sup>48</sup> are all-in by proxy here, whether they like it or not.<sup>49</sup> For some states, of course, this may be a forced proxy.<sup>50</sup>

Post-*National Federation*, all of the federalism chairs are re-arranged. Those states most opposed to the ACA express it by passive—or in the case of Missouri, active<sup>51</sup>—resistance to the federal-state cooperation inherent in exchange building.<sup>52</sup> Those states considered most amenable to the federal government's role in health care reform take control of their own state-based exchange development.<sup>53</sup> This is another gamble made and lost: state-operated exchanges leave the federal government as the overall reviewer, rather than the implementer, of state exchange compliance with the ACA.<sup>54</sup> This loss is two-fold. First, it represents a loss of

45. See Sarah Dash et al., *Health Policy Brief: Health Insurance Exchanges and State Decisions*, HEALTH AFF. 1 (July 18, 2013), [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=96](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=96) (noting that this degree of health care reform is unprecedented, thus raising unresolved questions like low enrollment and adverse selection).

46. See Letter from Ctr. for Consumer Info. & Ins. Oversight, Ctrs. for Medicare & Medicaid Servs., to Issuers on Federally-facilitated & State P'ship Exch. at 6–14 (Apr. 5, 2013), available at [http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014\\_letter\\_to\\_issuers\\_04052013.pdf](http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf) (stating that CMS will rely on state analyses so long as the state abides by the federally set standards and that CMS does not plan to duplicate any state reviews, thus leaving the review process to the states).

47. See *id.* at 5 (arguing that states will have flexibility to implement health plan exchanges based individualized state-reviews, provided the application is consistent with federal standards).

48. See McCarran-Ferguson Act, 15 U.S.C. § 1011–1015 (2006) (stating that states have the power to regulate or tax the business of insurance).

49. See Goodell, *supra* note 44 at 2–3 (noting that if states decide to opt-out of a pure State-based exchange, the states will then have federally run programs either in part or in whole).

50. See Pat Garofalo, *GOP Governors Play Politics With Life and Death*, U.S. NEWS & WORLD REPORT, OPINION (June 4, 2013), <http://www.usnews.com/opinion/blogs/pat-garofalo/2013/06/04/study-rejecting-obamacare-medicaid-expansion-costs-gop-governors-money> (quoting Texas Governor Rick Perry's unambiguous opposition to the ACA).

51. See MO. REV. STAT. § 376.1186(5) (2012) (prohibiting Missouri state employees from aiding ACA enrollment or implementation).

52. See LINDA J. BLUMBERG & SHANNA RIFKIN, URBAN INST., STATE-LEVEL PROGRESS IN IMPLEMENTATION OF FEDERALLY FACILITATED EXCHANGES: FINDINGS IN THREE CASE STUDY STATES 6 (June 2013), available at <http://www.urban.org/UploadedPDF/412844-State-Level-Progress-in-Implementation-of-Federally-Facilitated-Exchanges.pdf> (noting that while Alabama has not implemented an exchange, the state has not made explicit statements suggesting unwillingness to cooperate with the federal government's implementation of market reforms).

53. See *MassHealth: Roadmap to 2014*, MASS.GOV at 2–3 (May 1, 2013), <http://www.mass.gov/eohhs/docs/eohhs/cms-waiver/aca-transition-plan-draft.pdf> (noting that Massachusetts, in particular, has taken the lead on state specific health care reform by dismantling part of its signature Commonwealth Care infrastructure to make room for ACA-mandated infrastructure that dovetails with expanded Medicaid).

54. See STAN DORN, URBAN INST., STATE IMPLEMENTATION OF NATIONAL HEALTH

time, money, and attention. Second, it creates the false impression that the federal government has come to save the day, particularly in non-expansion states.

### III. THE AFFORDABLE CARE ACT'S GOALS FOR MEDICAID

The ACA's expanded Medicaid has implications for access, stability of enrollment, provider reimbursement, and administrative simplification. Each of these is designed to increase ease of access, improve stability of enrollment and continuity of care, bolster provider reimbursement, and streamline administration all with the goal of simplifying Medicaid's health insurance system.

#### A. Access to Care

The second Medicaid gamble surrounds the decision to begin to move Medicaid reimbursement as close to Medicare reimbursement as possible.<sup>55</sup> Medicaid reimbursement is set by the participating states with the caveat that the reimbursement system implemented not effectively restrict access to providers for Medicaid beneficiaries.<sup>56</sup> Medicare, though also based on a form of administered pricing, has not had its reimbursement scheme subject to the same political vagaries as has Medicaid.<sup>57</sup>

The third Medicaid gamble built into the ACA is that Medicaid expansion would look more like a step towards Medicare for all, rather than the subsidized purchase of commercial insurance.<sup>58</sup> Contained within this gamble is the understanding that states would embrace Medicaid expansion that offered the increased Medicaid population a program increasingly similar to that offered to the existing Medicare population.

---

REFORM: HARNESSING FEDERAL RESOURCES TO MEET STATE POLICY GOALS 9 (July 2010), available at <http://www.urban.org/UploadedPDF/412321-State-Implementation-of-National-Health-Reform.pdf> (noting that while states can implement state-based exchanges, all states will be held accountable through annual reports reviewed by HHS).

55. See Health Care and Education Reconciliation Act of 2010, 42 U.S.C. § 1396(a) (Supp. IV 2011) (noting that effective January 1, 2013, this section officially raises Medicaid payment rates for primary care and immunization service to Medicare rates at the federal expense, but is contingent upon state cooperation for the implementation).

56. See 42 U.S.C. § 1396a(a)(30)(A) (2006) (stating that reimbursement must be appealing to enough health care providers so that the amount of providers is sufficient to those in need of services).

57. See Paul Starr, *The Health-Care Legacy of the Great Society*, PRINCETON UNIV., [http://www.princeton.edu/~starr/articles/articles14/Starr\\_LBJ\\_HC\\_Legacy\\_1-2014.pdf](http://www.princeton.edu/~starr/articles/articles14/Starr_LBJ_HC_Legacy_1-2014.pdf) (last visited Feb. 19, 2014) (discussing how Medicare's national origins freed it from the political process that the state implemented Medicaid system developed).

58. Margaret Flowers, *Beyond The Spin, Some Facts About The Affordable Care Act*, AL JAZEERA (Oct. 14, 2013), <http://www.aljazeera.com/indepth/opinion/2013/10/beyond-spin-some-facts-about-affordable-care-act-2013101483653308300.html> (suggesting that the ACA moves the United States to larger privatization instead of a universal health care system).

### B. *Stability of Enrollment*

Medicaid enrollment is notoriously unstable as individuals pass in and out of Medicaid beneficiary status depending, for the most part, on their ability to verify eligibility at the time intervals required of a given state. Both health insurance administrative costs and health care delivery costs are increased when the same individuals churn in and out of Medicaid insured status, creating duplication of both health care paperwork and health care services.

Attempting to capture the savings from eliminating churn, states like Arkansas and Oklahoma, instead, have seized upon the Medicaid statutory language<sup>59</sup> combined with the HHS Rule 435.1015's language that Medicaid expansion funds may be used for the purchase of commercial insurance for newly eligible Medicaid beneficiaries so long as the cost is "comparable to the cost of providing direct [Medicaid] coverage."<sup>60</sup> The stability of Medicaid expansion in these states depends on the definition of "comparable."

It is too soon to tell how Arkansas proposes to meet this standard, while providing ACA-defined essential health benefits<sup>61</sup> through commercial insurance, but the hoped-for substantial savings from eliminating churn<sup>62</sup> in enrollment may help to foot the bill.

### C. *Bolstering Provider Reimbursement*

More troublingly, Arkansas is considering shifting the cost of part of the Medicaid expansion population's commercial insurance enrollment to those presently enrolled in Medicaid.<sup>63</sup> Although subject to the ACA's maintenance of

59. See 42 U.S.C. § 1396u-7 (2006) (stating that state flexibility in benefit packages sets only a benchmark for coverage, including the right to use commercial insurance).

60. See 42 C.F.R. § 435.1015 (2014) (stating that as long as the state meets the conditions provided, the state can use expansion funds to purchase commercial insurance); see also *Medicaid Proposal by Two Oklahoma GOP Lawmakers Has Some Appeal, But Obamacare Still a Bad Idea*, NEWSOK (May 6, 2013, 11:35am), <http://newsok.com/medicaid-proposal-by-two-oklahoma-gop-lawmakers-has-some-appeal-but-obamacare-still-a-bad-idea/article/3806070> (stating that a commercial insurance program in Oklahoma would cover up to 150,000 citizens and provide additional incentives to deter overutilization and abuse).

61. See Letter from Marilyn Tavenner, Admin., Ctrs. for Medicare & Medicaid Servs., to Andy Allison, Dir., Arkansas Dep't of Human Servs., (Sept. 27, 2013), available at <http://posting.arktimes.com/media/pdf/arkansasassignedapprovaltr.pdf> [hereinafter Letter from Marilyn Tavenner] (stating that Arkansas's private approach to Medicaid expansion has until November 2013 to fill in all details regarding the approved waiver application to use federal Medicaid expansion dollars to purchase commercial health insurance).

62. See *Smoothing Out Medicaid's 'Churn'*, WENDELL POTTER (June 10, 2013), <http://wendellpotter.com/2013/06/smoothing-out-medicaids-churn/> ("It's called churn because most people who are 'disenrolled' – to use industry jargon – are eventually reinstated. Their eligibility for Medicaid never changed. They lost coverage solely because of paperwork requirements or a slight and fleeting bump in pay because of having to work overtime during a given week").

63. See Adrianna McIntyre & Karan Chhabra, *Arkansas Proposal Still Fiddly in Practice*, PROJECT MILLENNIAL (Mar. 9, 2013), <http://projectmillennial.org/category/arkansas/page/2/>

effort provisions,<sup>64</sup> considerable leeway has been afforded to non-expansion states in interpreting these provisions.<sup>65</sup> Maine, for example, reduced original Medicaid enrollment by over 40,000 beneficiaries.<sup>66</sup>

Medicare-administered pricing is largely in the control of health care providers.<sup>67</sup> Conversely, Medicaid-administered pricing is very much in the control of state legislators.<sup>68</sup> This produces a tremendous variation in Medicaid provider reimbursement between and among the states.<sup>69</sup> It also produces considerable variance in physician Medicaid acceptance.<sup>70</sup> Considerable variance also exists between physician acceptance of new commercially insured patients and physician

---

(noting that e-mails sent among Arkansas state leaders proposed making up the state budget shortfalls from the Medicaid plan by taking money from those currently in Medicaid and giving it to those within the Medicaid/insurance expansion through the addition of copays, shifting enrollees to other programs, and eliminating funding for uncompensated care).

64. See Letter from Cindy Mann, Dir. of Ctr. For Medicaid, CHIP and Survey & Certification, Dep't of Health & Human Services, to State Medicaid Dirs. (Feb. 25, 2011), available at <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD11001.pdf> (informing State Medicaid Directors that states are obligated to maintain Medicaid "eligibility standards, methodologies, and procedures" under §1902(gg) and that states must also maintain CHIP maintenance of effort "eligibility standards, methods, and procedures" under §2101(d)(3)).

65. See Letter from Kathleen Sebelius, Sec'y of Health and Human Servs., to Governors (July 10, 2012), available at <http://capsules.kaiserhealthnews.org/wp-content/uploads/2012/07/Secretary-Sebelius-Letter-to-the-Governors-071012.pdf> (notifying governors that states have the choice of whether or not to participate in the Medicaid expansion, and should they choose to abstain from participation in the expansion, the federal government will exempt those whom Congress determines cannot afford coverage from the individual responsibility provision).

66. See Tracy Jan, *44,000 To Lose Medicaid Coverage In Maine*, BOSTON GLOBE (Feb. 23, 2013), <http://www.bostonglobe.com/news/nation/2013/02/22/maine-governor-cuts-medicaid-some-gop-colleagues-choose-expansion/QpZusfrOXCvm9EAh91YfnJ/story.html> (noting that 20,000 Maine residents have lost benefits due to immediate cuts, while another 24,000 are expected to lose benefits by the end of 2013).

67. See Robert E. Moffit & Alyene Senger, *Medicare's Rising Costs – and the Urgent Need for Reform*, 2779 BACKGROUND 1, 9 (2013), available at [http://s3.amazonaws.com/thf\\_media/2013/pdf/bg2779.pdf](http://s3.amazonaws.com/thf_media/2013/pdf/bg2779.pdf) (stating that some of the top down administrative prices in the current system are too low to be attractive to providers, meaning that providers essentially control costs by choosing which prices they will offer).

68. See Kevin Quinn, *Achieving Cost Control, Care Coordination, and Quality Improvement in the Medicaid Program*, 33 J. OF AMBULATORY CARE MGMT. 38, 42 (stating that though state legislatures vary in the leeway that they give to Medicaid agencies, in that some have broad discretion, while others require strict legislative approval, federal law give states control over Medicaid pricing).

69. See *Financing & Reimbursement*, MEDICAID.GOV, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Financing-and-Reimbursement.html> (last visited Nov. 15, 2013) (showing how the average state Federal Medical Assistance Percentage varies by the per capita income in each state and by each three-year cycle, and how states then establish their own Medicaid provider payment rates within federal requirements).

70. See Ellyn R. Boukus et al., *A Snapshot of U.S. Physicians: Key Findings from the 2008 Health Tracking Physician Survey*, 35 DATA BULLETIN 1, 3, 7–9 tbl.4a–b (Sept. 2009), available at <http://www.hschange.com/CONTENT/1078/1078.pdf> (showing that physician acceptance of new patients varied based on several characteristics, and that practices were less likely to accept new Medicaid patients).

acceptance of new Medicaid beneficiaries.<sup>71</sup> By 2011, the national average of physician acceptance rate for new Medicaid patients was sixty-nine percent.<sup>72</sup> This national average masked considerable state and regional variance, however.<sup>73</sup>

The crucial distinguishing variable between the states is that greater acceptance of new Medicaid patients appears to correlate with higher state Medicaid to Medicare fee ratios.<sup>74</sup> Remarkably, the administered pricing regimen doctors love to hate—Medicare—appears to function as the minimum acceptable reimbursement rate for other government funded health insurance.<sup>75</sup> Looked at from another perspective, the closer Medicaid provider reimbursement is to Medicare provider reimbursement in a given jurisdiction, the more likely Medicaid provider participation approaches Medicare provider participation levels.<sup>76</sup>

The ACA attempted to build on this insight by explicitly courting primary care providers to take on new Medicaid beneficiaries by awarding a two year pay raise based on Medicare-Medicaid primary care pay parity.<sup>77</sup> It is estimated the pay raise would total a seventy-three percent pay raise for primary care providers accepting Medicaid patients.<sup>78</sup> Federal approval of the two year pay raise has, however, been slow.<sup>79</sup> And it is set to terminate on schedule, although it did not begin on schedule.<sup>80</sup>

---

71. *See id.* (showing that there were wide differences in physician acceptance of patients, which depended on whether or not a patient had recently been added to the new Medicaid expansion).

72. *National Health Care Surveys: Physicians Accepting New Medicaid Patients by State*, NAT'L CTR. FOR HEALTH STATISTICS, [http://www.cdc.gov/nchs/data/factsheets/factsheet\\_nhcs.pdf](http://www.cdc.gov/nchs/data/factsheets/factsheet_nhcs.pdf) (last updated Dec. 2012).

73. *See id.* (noting that the percentage of physicians accepting Medicaid in New Jersey, for example, is only forty percent, which is far below the national average).

74. *Id.*

75. *See id.* (stating that states who had higher Medicaid-to-Medicare fee ratios accepted more new Medicaid patients).

76. *See Enhanced Medicaid Reimbursement Rates for Primary Care Services*, AM. COLL. OF PHYSICIANS, INC. 1 (2013), [http://www.acponline.org/advocacy/where\\_we\\_stand/assets/v1-enhanced-medicare-reimbursement-rates.pdf](http://www.acponline.org/advocacy/where_we_stand/assets/v1-enhanced-medicare-reimbursement-rates.pdf) (noting a survey that found half of primary care physicians would increase their Medicaid case load if Medicaid reimbursement rates were increased to the level of Medicare reimbursement rates).

77. *See* 42 U.S.C. § 1396(a)(13)(C) (2006) (increasing Federal Medical Assistance Percentages for primary care services for 2013 and 2014).

78. *See* STEPHEN ZUCKERMAN & DANA GOIN, KAISER FAMILY FOUND., HOW MUCH WILL MEDICAID PHYSICIAN FEES FOR PRIMARY CARE RISE IN 2013? EVIDENCE FROM A 2012 SURVEY OF MEDICAID PHYSICIAN FEES 2 (Dec. 2012), *available at* <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8398.pdf> (stating that Medicaid physician fees will increase for primary care services by 73%).

79. *See* Phil Galewitz, *Few Medicaid Docs Have Seen 2013 Pay Raise*, CAPSULES –THE KHN BLOG (July 16, 2013, 6:03 AM), <http://capsules.kaiserhealthnews.org/index.php/2013/07/few-medicare-docs-have-seen-2013-pay-raise/?referrer=search> (stating that many primary care doctors are still waiting for the Medicaid pay increase, though the government has just recently approved applications to start paying doctors the higher rates).

80. *See id.* (noting that though the government has delayed the two year pay increase, it will still end less than eighteen months after it begins).

Part of the difficulty has been logistical; the Medicaid managed care fee schedule is not easily mapped onto Medicare's dominant fee-for-service reimbursement schedule.<sup>81</sup> A further part of the difficulty has been political, where the Obama administration found itself simultaneously requested to approve California's application for the fee increase, while endorsing California Medicaid's determination to keep Medi-Cal reimbursement rates among the lowest in the nation.<sup>82</sup> The early administratively-oriented delays bred further delays as uncertainty over reimbursement increases prevented some providers from identifying themselves as willing to accept Medicaid patients<sup>83</sup>—closing the window on retroactive reimbursement that might have counterweighed administrative delays.<sup>84</sup>

### *1. How Low Can You Go?*

Nowhere are the Medicaid reimbursement laws more contentious, and also more portentous, than in California.<sup>85</sup> California has over seven million Medicaid beneficiaries as of this writing, a number ultimately expected to grow by as much as a further two million under the ACA's Medicaid expansion.<sup>86</sup> California is different because of the magnitude of the scale. California is a bellwether state and Medi-Cal is a bellwether Medicaid program.<sup>87</sup>

---

81. *See id.* (stating that one of the obstacles in implementing the program is in determining how Medicaid managed firms can apply the raise when doctors receive a monthly fee per patient rather than for each patient's claim).

82. *See id.* (showing the political conflicts in Obama's approval of California's request for the lower pay, and California Medicaid officials' request for the higher pay).

83. *See id.* (noting that many states set the deadline for April or May for doctors to attest their willingness to accept new Medicaid patients; however, many physicians missed the deadline and as a consequence, these physicians will fail to get the pay increase unless they fill out a form showing that they are licensed as a family doctor, pediatrician, or internist).

84. *See id.* (stating that doctors who missed their state's deadline will only be able to receive retroactive pay once they fill out a form showing that they are licensed as a family doctor, pediatrician, or internist).

85. *See* Bruce C. Vladeck & Stephen I. Vladeck, Op-Ed., *Killing Medicaid the California Way*, N.Y. TIMES, Oct. 13, 2011, at A31 (stating that many problems exist in implementing Medicaid reimbursement laws in California, including: 1) the United States Department of Health and Human Services does not have the resources to ensure compliance with the equal access provision; 2) the department would encounter issues with the enforcement budget; 3) even with proper funding, the department has limited authority to provide remedies for violations; and 4) even if the justices rule for California, Congress could potentially fix the problems outlined previously, but it is unlikely that there will be a "true legislative fix").

86. *See* CAL. BUDGET PROJECT, EXPANDING HORIZONS: KEY FACTS ABOUT THE MEDI-CAL PROGRAM AS CALIFORNIA IMPLEMENTS HEALTH CARE REFORM 48 (Apr. 2013), [http://www.cbpf.org/pdfs/2013/130402\\_Expanding\\_Horizons.pdf](http://www.cbpf.org/pdfs/2013/130402_Expanding_Horizons.pdf) (noting that the Medicaid Program in California currently provides coverage for over 7 million residents); Christine Vestal, *Why new Medicaid enrollment is soaring*, USA TODAY (Nov. 6, 2013, 12:12 PM), <http://www.usatoday.com/story/news/nation/2013/11/06/new-medicare-enrollment-healthcare/3453929/> (stating that the ACA Medi-Cal program would include 1.4 additional residents).

87. *See* Chris Rauber, *California Accounts For One-Third Of Obamacare's Puny 106,000 October Enrollees*, S. F. BUS. TIMES (Nov. 13, 2013, 12:48 PM), <http://www.bizjournals.com/>

California is also different because of the state's enduring resistance to moving Medicaid reimbursement closer to that of Medicare.<sup>88</sup> This is a storied history, whose modern version began with a 2008 decision to reduce Medi-Cal provider reimbursement rates.<sup>89</sup> Litigation ensued, testing the idea that Medicaid reimbursement rates might move so low that Medicaid's access provisions would be violated.<sup>90</sup> The Ninth Circuit agreed that the proposed cuts impinged on Medicaid beneficiary access.<sup>91</sup> The Obama administration then endorsed the proposed cuts.<sup>92</sup> In 2012, the United States Supreme Court sent the case back to the Ninth Circuit Court of Appeals where the reimbursement cuts were eventually approved.<sup>93</sup> A staged roll out of the reimbursement cuts began September 1, 2013.<sup>94</sup>

## 2. Medicaid Reimbursement Rates and Patient Access to Care Issues

Patient access to Medicaid care is not widely studied. There is no nationwide data set on Medicaid patient wait times or physician acceptance of new Medicaid

---

sanfrancisco/blog/2013/11/california-accounts-for-one-third-of.html?s=print (stating that California has long been regarded as a bellwether state for the Affordable Care Act); Cheryl Clark, *1 in 3 Medi-Cal Enrollees Delay Care on Cost Concerns*, HEALTHLEADERS MEDIA (May 31, 2012), <https://www.healthleadersmedia.com/print/fin-280737/1-in-3-MediCal-Enrollees-Delay-Care-on-Cost-Concerns> (stating that many see Medi-Cal as a bellwether program).

88. See Vladeck & Vladeck, *supra* note 85 (discussing the California Legislature's 2008 "across-the board 10 percent cut" in reimbursement rates for Medi-Cal).

89. *Id.*

90. See *Toby Douglas v. Indep. Living Ctrs. of S. Cal., Inc.*, 132 S. Ct. 1204, 1209 (2012) (noting that Medicaid providers and beneficiaries brought a series of cases arguing that California's reductions in the Medicaid reimbursement rates violated the federal provisions).

91. *Indep. Living Ctr. of S. Cal. v. Maxwell-Jolly*, 572 F.3d 644, 657 (9th Cir. 2009), *vacated and remanded by Toby Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204 (2012) ("Even if we were to interpret § 30(A) to mandate a substantive rather than procedural result, the ten percent rate reduction might still conflict with the quality of care and access provisions of § 30(A), as the cuts have apparently forced at least some providers to stop treating Medi-Cal beneficiaries.").

92. See Letter from Gloria Nagle, Assoc. Reg'l Adm'r, Div. of Medicaid & Children's Health Operations, to Toby Douglas, Director, California Department of Health Care Serv. (Oct. 27, 2011) (determining that California's reduction in reimbursement rates complied with section 1902(a)(30)(A) of the Social Security Act).

93. See *Toby Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204, 1211 (2012) (remanding the cases to the Ninth Circuit to decide whether the cases "may proceed directly under the Supremacy Clause not that the agency has acted"); *Managed Pharmacy Care v. Sebelius*, 716 F.3d 1235, 1240–41 (9th Cir. 2013) (holding that "the Secretary's approval of California's requested reimbursement rates . . . is entitled to deference").

94. See *Appellate Rejects Effort to Block Medicaid Cuts in California*, MODERN HEALTHCARE (July 2, 2013), <http://www.modernhealthcare.com/article/20130702/NEWS/307029935> (reporting that payment reductions in Medi-Cal will be implemented on September 1, 2013); see also *Implementation of AB 97 Reductions*, DEP'T OF HEALTH CARE SERVICES (2013), <http://www.dhcs.ca.gov/Documents/AB97ImplementationAnnouncemen081413.pdf> (listing provider categories impacted by the implementation of rate reductions and the dates upon which these provider categories will begin to see the reductions).

patients.<sup>95</sup> Locality specific and disease specific data is partial, but illuminating, however.<sup>96</sup>

For nine consecutive years, the Massachusetts Medical Society surveyed patient access to care data, including surveying acceptance rates of Medicaid (known as MassHealth in Massachusetts) by physicians.<sup>97</sup> Only seven physician specialties are surveyed, but family medicine and internal medicine, the two major primary care specialties, are among them.<sup>98</sup> These surveys have significant limitations, not the least of which is that they tell the patient access tale from the provider's perspective, but they are still useful for comparative data.<sup>99</sup> Both in 2011 and 2012, for example, primary care specialties were the least likely to accept MassHealth,<sup>100</sup> with only sixty-six percent of internists participating.<sup>101</sup> By contrast, ninety percent of family medicine practitioners accepted Medicaid and eighty five percent of internists surveyed accept Medicare.<sup>102</sup> In that only forty-five percent of all internists are accepting new patients of any type,<sup>103</sup> this likely leaves somewhat less than sixty-six percent of internists accepting new Medicaid patients.

Access to specialists, ironically, is easier than access to primary care providers in Massachusetts, creating a sort of Medicaid primary care bottleneck.<sup>104</sup>

---

95. *But see* Anna S. Sommers et al., *Physician Willingness and Resources to Serve More Medicaid Patients: Perspectives from Primary Care Physicians*, 2 MEDICARE & MEDICAID RESEARCH E1, E2-E3 (2011) (using data from a national survey of physicians to compare the number of primary care physicians to the number of accepted patients with Medicaid). *See generally* THOMAS C. BUCHMUELLER ET AL., NAT'L BUREAU OF ECON. RESEARCH, THE EFFECT OF MEDICAID PAYMENT RATES ON ACCESS TO DENTAL CARE AMONG CHILDREN 7-8 (2013) [hereinafter BUCHMUELLER ET AL.] (discussing the partial nature of the Medicaid data set as part of the methodology discussion of study concerning the relationship between Medicaid reimbursement and Medicaid access for pediatric dental services).

96. *See generally* BUCHMUELLER ET AL., *supra* note 95, at 7 (noting that most of the studies analyzing the relationship between Medicaid physicians and access to care are disease specific or "come[] from research on single states.").

97. *See generally* MASS. MED. SOC'Y, 2013 MMS PATIENT ACCESS TO CARE STUDY (2013) (reporting the findings of the Massachusetts Medical Society's ninth annual health care wait times study for the following specialties: family medicine, internal medicine, cardiology, gastroenterology, obstetrics/gynecology, orthopedic surgery, and pediatrics).

98. *Id.* at 3.

99. *See* JOHN HSU ET AL., MASS. MED. SOC'Y, MASSACHUSETTS MEDICAL SOCIETY: PHYSICIAN SURVEY ON GLOBAL PAYMENTS 3 (2012) (discussing the limitations of the study, which includes basing the results on "physician self reported perceptions").

100. *See* 2013 MMS PATIENT ACCESS TO CARE STUDIES, *supra* note 97, at 9 (reporting that MassHealth acceptance was the lowest in 2011 and 2012 in internal medicine offices and family medicine offices, which are two examples of primary care specialties); *see also* COMMON HEALTH FOR THE COMMONWEALTH: MASSACHUSETTS REPORT ON PREVENTABLE DETERMINANTS OF HEALTH, MASS. HEALTH COUNCIL 7 (Hollis Burkhardt et al. eds., 7th ed. 2012) (reporting that primary care specialties were the least likely to accept MassHealth).

101. *See* 2013 MMS PATIENT ACCESS TO CARE STUDY, *supra* note 97, at 9 fig.4.

102. *See id.* at 12, 15.

103. *Id.* at 13 (finding "[t]he number of internal medicine physicians accepting new patients" fell from fifty-one percent to forty-five percent).

104. *See MMS Study Shows Patient Wait Times for Primary Care Still Long*, MASS. MED.

Whether there is a shortage of primary care providers is a contentious topic.<sup>105</sup> The primary care bottleneck might be just as easily removed by the expansion of non-physician primary care gatekeepers.<sup>106</sup> But the gamble here is that this debate—driven by public pressure—will force resolution of the Massachusetts primary care access bottleneck.

The adequate access at lower rates conundrum seems particularly pronounced in rural areas.<sup>107</sup> Missouri, for example, pays half the Medicare primary rate for Medicaid primary care services, compared to the rest of the region.<sup>108</sup> It is suggested that while Medicaid “reimbursement levels have a linear relationship with provider participation”.<sup>109</sup> Medicaid reimbursement rates alone cannot tell the story of relatively low primary care provider participation in Medicaid.<sup>110</sup>

#### D. Administrative Challenges

A parallel story on administrative complexity, particularly under capitated contracts, should also be told.<sup>111</sup> Increases in paperwork and capitation combined

---

SOC’Y (July 15, 2013), <http://www.massmed.org/News-and-Publications/MMS-News-Releases/MMS-Study-Shows-Patient-Wait-Times-for-Primary-Care-Still-Long/#.UobTivkqiSo> (finding access to specialists to be easier than access to primary care); 2013 MMS PATIENT ACCESS TO CARE STUDY, MASS. MED. SOC’Y 10, 16 (2013) (reporting that specialists such as cardiologists are accepting 85% of new patients, whereas only 51% of all family medicine physicians are accepting new patients); *see also* BUILDING A PRIMARY CARE WORKFORCE FOR THE 21ST CENTURY, NAT’L ASS’N OF CMTY. HEALTH CTRS. ET AL. 1 (2008) (discussing how the implementation of universal insurance coverage in Massachusetts “has created a primary health care bottleneck”).

105. *See* Kevin Sack, *In Massachusetts, Universal Coverage Strains Care*, N.Y. TIMES (Apr. 5, 2008), <http://www.nytimes.com/2008/04/05/us/05doctors.html?pagewanted=all> (discussing the current debate about the shortage of primary care providers, and how some researchers have found that the high number of doctors in the U.S. is causing an overutilization of the system).

106. *See* David Muzina, *A Fix for the Health Decision Bottleneck*, HEALTHCARE INSIGHTS (May 1, 2013), <http://lab.express-scripts.com/industry-updates/a-fix-for-the-health-decision-bottleneck/> (arguing that the primary care bottleneck could be alleviated by “pushing less critical components of healthcare down to non-physicians.”). Of course, the necessary relaxation of relevant scope of practice laws and doctrines might not be as simple. *See* Mark D. Schwartz, *Health Care Reform and the Primary Care Workforce Bottleneck*, 27 J. GEN. INTERN. MED. 469, 469–71 (2011) (discussing the different laws and policies that need to be implemented in order to address the serious workforce bottleneck issue that has been created due to high patient demand and low physician supply, and how the implementation of these laws will not be a simple process).

107. *See* PAM SILBERMAN ET AL., THE IMPACT OF MEDICAID CUTS ON RURAL COMMUNITIES, NORTH CAR. RURAL HEALTH RESEARCH AND POLICY ANALYSIS CTR. 14 (2005) (finding that barriers to health care access are “more acute in rural areas”).

108. MO. FOUND. FOR HEALTH AND THE HEALTH CARE FOUND. OF GREATER KAN. CITY, MEDICAID RATES AND PROVIDER PARTICIPATION: CONSIDERATIONS FOR MISSOURI POLICY MAKERS, 5 (2008).

109. *Id.*

110. *Id.* at 4 (discussing how the reduction of reimbursement rates when state budgets are tight and increasing the reimbursement rates when state revenues increase only brings to light the complications of provider participation in Medicaid).

111. *See id.* at 7 (arguing that doctors may be less eager to accept the administrative overhead

with low payment levels create the perfect storm of limited access to primary care for Medicaid beneficiaries.<sup>112</sup>

Huge systematic changes in physician employment are also taking place in ways that may increase Medicaid payment acceptability among primary care physicians as well.<sup>113</sup> Physicians are increasingly employees of health care institutions rather than self-employed.<sup>114</sup> Physician employees and physicians in large group practices are more likely to accept Medicaid, often dropping charity care in the process.<sup>115</sup> Whether this is driven by the fact that larger, better staffed practices enable primary care providers to deal with the bureaucracy of Medicaid or whether larger practices are better equipped to bill for all services, Medicaid beneficiaries are more likely than other insured individuals to receive care in larger practices or institutional settings.<sup>116</sup>

Finally, Medicaid beneficiary access to care is also a function of community characteristics and demographics. Low income individuals disproportionately live in medically underserved areas.<sup>117</sup> Modest adjustments to Medicaid reimbursement rates are unlikely to change this.<sup>118</sup> Patterns of residential segregation by income<sup>119</sup>

---

associated with managed care and capitated contracts as compared to fee-for-service reimbursement).

112. *See id.* at 6–7 (arguing that fee levels, administrative overhead, and managed care penetration are contributing factors to Medicaid beneficiaries limited access to primary care).

113. *See id.* at 7 (explaining that larger practices are more likely to see more Medicaid patients); *see also* THE PHYSICIANS FOUND., HEALTH REFORM AND THE DECLINE OF PHYSICIAN PRIVATE PRACTICE 7 (2010), available at [http://www.physiciansfoundation.org/uploads/default/Health\\_Reform\\_and\\_the\\_Decline\\_of\\_Physician\\_Private\\_Practice.pdf](http://www.physiciansfoundation.org/uploads/default/Health_Reform_and_the_Decline_of_Physician_Private_Practice.pdf) [hereinafter THE PHYSICIANS FOUND.] (describing the systematic changes in health care where large practices are now the majority).

114. *See* THE PHYSICIANS FOUND., *supra* note 113, at 7 (noting that as compared to 1900, small physician practices have become the minority of physician practice types).

115. *See* MO. FOUNDATION FOR HEALTH, *supra* note 115, at 6 (stating that physician employees and physicians in large group are more likely to drop charity care and to start accepting Medicaid patients compared to physicians who are owners or in small practices).

116. *See* PETER J. CUNNINGHAM & JESSICA H. MAY, CTR. FOR STUDYING HEALTH SYSTEM CHANGE, MEDICAID PATIENTS INCREASINGLY CONCENTRATED AMONG PHYSICIANS 2–3 (2006), available at <http://www.hschange.com/CONTENT/866/866.pdf> (noting that for various reasons, such as low Medicaid payment rates and high administrative burdens, the concentration of Medicaid patient care in large group and institution based practices is increasing while the care of Medicaid patients continues to shift away from small group practices).

117. *See People in Medically Underserved Areas*, NAT'L WOMEN'S LAW CTR., (2010), available at <http://hrc.nwlc.org/status-indicators/people-medically-underserved-areas> (explaining that a lack of accessible health care services, or living in a medically underserved area, is particularly acute for poor and low-income people).

118. *See* LEIGHTON KU ET AL., GEIGER GIBSON/RCHN CMTY. HEALTH FOUND. RESEARCH COLLABORATIVE, ESTIMATING THE EFFECTS OF HEALTH REFORM ON HEALTH CENTERS' CAPACITY TO EXPAND TO NEW MEDICALLY UNDERSERVED COMMUNITIES AND POPULATIONS 6 (2009), available at [http://sphhs.gwu.edu/departments/healthpolicy/DHP\\_Publications/pub\\_uploads/dhpPublication\\_9889E996-5056-9D20-3D1F89027D3F9406.pdf](http://sphhs.gwu.edu/departments/healthpolicy/DHP_Publications/pub_uploads/dhpPublication_9889E996-5056-9D20-3D1F89027D3F9406.pdf) (arguing that while higher funding levels may allow health centers to expand and serve additional low-income people in medically underserved areas, an estimated 56 million people will remain underserved due to being “medically disenfranchised”).

119. *See* Dolores Acevedo-Garcia et al., *Toward A Policy-Relevant Analysis Of Geographic*

and the health care deserts that accompany them<sup>120</sup> are deeply-seated in American patterns of residential segregation.

Seeking the solution to Medicaid budget battles in provider budgets is a gamble on its own terms. Although substantial data exists that Medicaid provider reimbursement cuts correlate with lower utilization,<sup>121</sup> it is still too soon to say whether Medicaid provider reimbursement cuts twinned with expanded Medicaid eligibility will produce the same effect.

In conventional fee-for-service Medicare, there is even some evidence that provider reimbursement cuts lead to more and not less care.<sup>122</sup> Price levels, in fee-for-service medicine, are a one dimensional approach to cost containment.<sup>123</sup> Medicaid is often not a fee-for-service program, however, so the analogy may not be entirely apt.<sup>124</sup>

#### IV. VISIONS FOR MEDICAID

##### A. *Why Make Medicaid Look More Like Medicare?*

The conventional narrative on government-funded health insurance in the United States is that programs for poor people are poor programs.<sup>125</sup> Further, our collective desire to segregate health insurance by economic class is supposed to demonstrate our collective hostility toward using government funded health insurance as an anti-poverty program,<sup>126</sup> hence our reluctance to be generous with

---

*And Racial/Ethnic Disparities In Child Health*, 27 HEALTH AFF. 321, 322 (2008) (noting that mounting evidence suggests that residential segregation is a key factor of health disparities). *But see* P. Lobmayer, & R. G. Wilkinson, *Inequality, Residential Segregation by Income, and Mortality in US Cities* 56 J. EPIDEMIOL. CMTY. HEALTH 183, 186 (2002) (concluding that income inequality is seemingly related to mortality independent of economic segregation).

120. *See* Acevedo-Garcia et al., *supra* note 119, at 321 (noting that mounting evidence suggests that residential segregation is a key factor of health disparities).

121. *See* Julia Bienstock, *Administrative Oversight of State Medicaid Payment Policies: Giving Teeth to the Equal Access Provision*, 39 FORDHAM URB. L.J. 805, 807 (2012) (noting that states nonetheless continue to cut Medicaid reimbursement rates).

122. Adrianna McIntyre, *It's Possible That Price Cuts Lead To More Care, Not Less*, INCIDENTAL ECONOMIST (July 31, 2013), <http://theincidentaleconomist.com/wordpress/its-possible-that-price-cuts-lead-to-more-care-not-less> (arguing that provider reimbursement cuts, such as those in the area of chemotherapy, actually lead to more treatment).

123. *See id.* (arguing that price is one level in cost containment).

124. *See* KAISER COMM'N. ON MEDICAID AND THE UNINSURED, MEDICAID MANAGED CARE: KEY DATA, TRENDS, AND ISSUES 1 (2012), *available* at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8046-02.pdf> (noting Medicaid's increased use of managed care, as opposed to fee for service). It is estimated that approximately seventy percent of all Medicaid beneficiaries are enrolled in some kind of Medicaid managed care, though disabled and senior beneficiaries remain disproportionately enrolled in fee-for-service Medicaid, accounting for about eighty percent of Medicaid spending. *Id.*

125. *See* CHRISTOPHER HOWARD, THE WELFARE STATE NOBODY KNOWS: DEBUNKING MYTHS ABOUT U.S. SOCIAL POLICY 6 (2007) (explaining that the common criticism "programs for the poor are poor programs" often means that programs for the poor, such as Medicaid, are politically vulnerable).

126. *See* OLSON, *supra* note 36, at 2–3, 5 (noting that public policy and rhetoric towards

government-funded health insurance programs for the poor.<sup>127</sup> And so the narrative goes that in Medicare—in stark contrast—we see the fullest flowering of our collective aspiration to protect all or most of our seniors from the vicissitudes of health care and health insurance markets but on the condition that little or no means testing<sup>128</sup> temper our generosity. It is, as it were, not so much an aversion to helping the poor as an aversion to singling out the poor alone for assistance.<sup>129</sup> This is why proposals for “Medicare for All” or “Federal Employees Health Benefits for All” routinely cycle through our great public debates on health care reform.<sup>130</sup>

We are conflicted. Our distaste for the poor is at odds with our desire to level entitlements in the name of equality.<sup>131</sup> Both drive us further away from income based programs and toward categorical eligibility as we re-conceive government-funded health insurance. It may be that the ACA’s public perception problem is, as David Orentlicher notes, that it “looks much more like Medicaid than Medicare”<sup>132</sup> and that this resemblance generates resistance among Americans. By this reckoning, however, “Medicare for All” should be a crowd pleaser. Understanding why it is not and has not been the American go-to health care reform proposal tells us something about ourselves.

---

Medicaid, as detested by some, signifies an unrestricted right to aid with indifference to personal responsibility).

127. *See id.* at 2 (noting that officials have sought to cut Medicaid funding frequently to the detriment of Medicaid enrollees).

128. *See id.* at 26 (explaining that since inception, Medicaid, as a means tested “benevolence” program, was often stigmatized and connoted dependence while Medicare, based on the concept of social insurance, was considered a national entitlement). The introduction of very modest Medicare means testing, at the margin, has been controversial as compared to Medicaid. *See* Andrew G. Biggs, *Means Testing and Its Limits* 9 NAT’L. AFF. 97, 103–04 (2011), available at [http://www.nationalaffairs.com/doclib/20110919\\_Biggs.pdf](http://www.nationalaffairs.com/doclib/20110919_Biggs.pdf) (explaining the opposition, from both ends of the political spectrum, to the means-testing of Medicare); *E.g.*, Paul Krugman, *Means-testing Medicare*, N.Y. TIMES (July 24, 2011), <http://krugman.blogs.nytimes.com/2011/07/24/means-testing-medicare> (arguing that means-testing Medicare, in the same fashion as Medicaid, is a badly designed idea and unfair form of taxation).

129. *See* Biggs, *supra* note 128, at 103 (explaining that many politicians believe that Americans will not support programs “in which redistribution toward the poor is too overt”).

130. *See* David Orentlicher, *Rights to Healthcare in the United States: Inherently Unstable*, 38 AM. J.L. & MED. 326, 346 (2012) (noting the single-payer debate during the passage of the ACA shows the present-day political barrier to enacting a Medicare-for-all system). *See generally* Ida Hellander, *Evidence Supports Medicare For All*, HEALTH AFF. BLOG (June 7, 2013), <http://healthaffairs.org/blog/2013/06/07/evidence-supports-medicare-for-all> (showing that even after the passage of the ACA, debate over “Medicare for All” is still alive and well).

131. *See* NORMAN DANIELS ET AL., BENCHMARKS OF FAIRNESS FOR HEALTH CARE REFORM 15–16 (1996) (explaining that commentators have supported the notion that Americans lack the culture or values to support universal access to medical service, but at the same time claim, poll after poll, that access to health care is a right).

132. *The Unraveling of Obamacare*, HEALTH LAW PROF BLOG (July 3, 2013), [http://lawprofessors.typepad.com/healthlawprof\\_blog/2013/07/obamacare-and-the-instability-of-us-rights-to-health-care.html](http://lawprofessors.typepad.com/healthlawprof_blog/2013/07/obamacare-and-the-instability-of-us-rights-to-health-care.html).

If the ACA's goal was to make Medicaid look more like Medicare, it was probably designed to make Medicaid look more like Medicare as Medicare for All's advocates have advanced it<sup>133</sup>—a universal health care system—than as it was passed—a categorical eligibility based system with no means testing.<sup>134</sup> Just as the passage of an abbreviated Medicare marked another skirmish in the war for Medicare's soul, the abbreviation of the ACA by the Supreme Court has marked another skirmish in the war over the Medicaid's soul.

Surely the ACA's implementers knew what they were doing when they began a campaign to convert all relevant Code of Federal Regulations language from Medicaid enrollees to Medicaid beneficiaries.<sup>135</sup> Medicaid enrollees have always just been that—unlike Medicare beneficiaries—a naming convention emphasizing the provisional, conditional nature of the Medicaid entitlement. And the announcement accompanying the change acknowledged as much.<sup>136</sup>

The Code of Federal Regulations was revised on 15 and 16 July 2012 to change the word “recipient” to “beneficiary.”<sup>137</sup> The following is excerpted from 77 FR 29002-01, which appeared on May 16, 2012 in the Federal Register:

Removal of the Term “Recipient” for Medicaid: We have removed the term “recipient” from current CMS regulations and made a nomenclature change to replace “recipient” with “beneficiary” throughout the CFR. In response to comments from the public to discontinue our use of the unflattering term “recipient” under Medicaid, we have been using the term “beneficiary” to mean all individuals who are eligible for Medicare or Medicaid services.<sup>138</sup>

Just what is unflattering about the term “recipient” may be understood only in context; similarly, what is empowering about “beneficiary” may also only be

133. See OLSON, *supra* note 36, at 24 (noting that Johnson succeeded in passing universal health insurance for the elderly with Medicare).

134. See Austin Frakt, *Bye-Bye Medicaid Asset Test*, INCIDENTAL ECONOMIST (Apr. 13, 2010), <http://theincidentaleconomist.com/wordpress/bye-bye-medicaid-asset-test/> (arguing that the ACA's categorical net income standard does away with Medicaid means-testings); Olson, *supra* note 36, at 24 (noting that Johnson, like his predecessor Kennedy, proposed universal health insurance for the elderly). Cf. Orentlicher, *supra* note 142, at 330 (noting, in contrast to what was proposed, as passed, Medicare took on three distinct forms: Medicare Part A and B for all seniors, and Medicaid as a limited, means-tested, program for the poor).

135. See Medicare and Medicaid Program; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction, 77 Fed. Reg. 29,002, 29,002–03 (May 16, 2012) (to be codified at 42 C.F.R. ch. 4) (noting the change from the term “recipient” to “beneficiary” to mean all individuals eligible for Medicare or Medicaid services).

136. See Medicare and Medicaid Program; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction, 77 Fed. Reg. 29,002, 29,002–03 (explaining the change from “recipient” to “beneficiary” throughout the C.F.R. as a result of public perception of “recipient” as “unflattering”).

137. *Id.* at 29,002 (the regulations became effective July 16, 2012).

138. *Id.* at 29,002–03.

understood in context.<sup>139</sup> Medicare and Medicaid beneficiaries now stand on equal dignatorial ground.

*B. Should Medicaid Look More Like Commercial Insurance?*

*1. The California Story: Expanding Medicaid While Lowering Medicaid Provider Reimbursement*

Nowhere is our ambivalence over Medicaid, as an anti-poverty program or as a playing field leveler, more fully expressed than in California's current drive to expand Medicaid to one in four Californians while continuously seeking to lower Medicaid provider reimbursement to ever lower levels.<sup>140</sup> With one hand, California floods the market with the newly Medicaid eligible,<sup>141</sup> and with the other it drives Medicaid provider reimbursement—and Medicaid provider participation—even lower. Consequently, this creates the paradox of more Medicaid eligible Californians competing for even fewer Medicaid participating providers.<sup>142</sup> Medicaid, in this context, is more a license to hunt than a guarantee to access.

Medicaid reimbursement is part of a system of administered pricing. By contrast, commercial insurance must, by definition, incorporate provider rates set by the market. Medicaid provider reimbursement rates are set by each participating state subject only to the limiting caveat that the rates not be organized in such a way as to explicitly limit the beneficiaries' access to providers.<sup>143</sup> Never definitively defined and rarely tested, the important question of how low a state may go in setting Medicaid provider reimbursement rates to restrict Medicaid

---

139. Recipient is used to identify a receiver of something, whereas beneficiary identifies a person who is helped by something. See *Recipient*, MERRIAM-WEBSTER ONLINE, <http://www.merriam-webster.com/dictionary/recipient> (last visited Oct. 19, 2013) (defining recipient as "a person who receives something"); *Beneficiary*, MERRIAM-WEBSTER ONLINE, <http://www.merriam-webster.com/dictionary/beneficiary> (last visited Oct. 19, 2013) (defining beneficiary as "a person . . . that is helped by something"). The distinction may lie in the charitable recipient implication of recipient and the earned benefit implication of beneficiary.

140. See *The California Health Benefit Exchange Aligned with Medi-Cal*, CAL. HEALTHCARE FOUND. 1, 7 (Oct. 2011) (noting that California expects to have one in four of its citizens enrolled in Medi-Cal by 2014, but that Medi-Cal physician reimbursement rates are significantly lower than those of private insurers).

141. See Daniel Weintraub, *Much of ACA Already in Place*, CAL. HEALTH REPORT (Aug. 19, 2013), <http://www.healthycal.org/archives/13326> (noting that California has expanded coverage for its low-income residents).

142. See *Physician Participation in Medi-Cal*, CAL. HEALTHCARE FOUND. (July 2010) <http://www.chcf.org/publications/2010/07/physician-participation-in-medical> (discussing a study that found California physicians to be much less likely to accept new Medi-Cal patients than patients who are privately insured or on Medicare, despite the expected growth in eligible Medi-Cal patients due to new rules).

143. See 42 U.S.C. § 1396a(19) (2006) (ensuring that the state plan for medical assistance "provides safeguards" that are in the "best interest of the recipient"); see also 42 U.S.C. § 1396a(11)(B)(ii) (2006) (providing that the state plan for medical assistance must reimburse any "agency, institution, or organization" for the individual care provided to a recipient).

beneficiaries' access to health care remains undetermined, but California's how-low-can-you-go litigation is instructive.<sup>144</sup>

There is, however, a discernible pattern where making Medicaid broader has also made it thinner. As Avik Roy points out “that there is a rough correlation of states with extensive Medicaid programs to those with poor [Medicaid] physician reimbursement.”<sup>145</sup> Roy concludes from this that manipulation of Medicaid provider rates is the mechanism by which blue states reduce their Medicaid populations without running afoul of federal constraints on open Medicaid beneficiary disenrollment.<sup>146</sup> But this is too simple. Although Medicaid reimbursement rates appear to play a significant role in Medicaid provider participation in the program,<sup>147</sup> Roy cannot square this method of Medicaid enrollment re-calibration with states' goal of gaming the system by increasing Medicaid spending.<sup>148</sup> States cannot game the federal matching dollars if they do not have expenditures, so clearly something more complex is going on here. The problem is that provider “underpayment” and “overpayment” are relative terms. Roy compares Medicaid provider reimbursement to Medicare reimbursement, commercial insurance reimbursement, and to Medicaid reimbursement across states without any consideration of provider supply, market dominance, and market concentration.<sup>149</sup> Reading reimbursement rates as if they made sense across markets is unhelpful.

---

144. See *Raising Medicaid Reimbursement to Increase Provider Participation*, MISSOURI FOUND. FOR HEALTH, available at [http://www.mffh.org/mm/files/Factsheet\\_ReimbursementRates.pdf](http://www.mffh.org/mm/files/Factsheet_ReimbursementRates.pdf) (last visited Jan. 23, 2014) (explaining that the federal Medicaid law does not set precise requirements for state reimbursement of individual medical providers); see, e.g., *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204 (2012) (involving a challenge to California statutes that reduce Medicaid reimbursement).

145. Avik Roy, *How Do Blue States Expand Medicaid? By Paying Doctors Less*, FORBES.COM, THE APOTHECARY BLOG (July 23, 2012, 11:24pm), <http://www.forbes.com/sites/theapothecary/2012/07/23/how-do-blue-states-expand-medicaid-by-paying-doctors-less/>.

146. See *id.* (stating that the current recession has provided less Medicaid funding from the federal government to the states, and thus states pay doctors less to reduce Medicaid spending without decreasing Medicaid rolls).

147. See Chapin White, *A Comparison of Two Approaches to Increasing Access to Care: Expanding Coverage versus Increasing Physician Fees*, 47 HEALTH SERVS. RESEARCH 963, 979 (June 2012) (explaining that there is a correlation between utilization of physicians participating in Medicaid and reimbursement of these physicians).

148. See *Medicaid: Designed to Fail*, PHYSICIANS FOR REFORM, <http://www.physiciansforreform.org/our-plan/medicare-medicaid/medicaid-designed-fail/> (last visited Nov. 21, 2013) (identifying the “game” played by states whereby they increase Medicaid spending in order to receive more federal money).

149. See Roy, *supra* note 145 (stating only the percentage different states pay through Medicare versus what private insurers pay).

### C. Medicaid Expansion

#### 1. Arizona Retains Its Original 1980s Waiver

Arizona, to this date, operates what it describes as its state Medicaid program under a section 1115 waiver originally bargained in the 1980s.<sup>150</sup> Ultimately coerced by the cost of uncompensated indigent care, Arizona came onboard with original Medicaid on October 1, 1982.<sup>151</sup> Arizona's current governor does not seem eager to be a poster child for health care reform done right, outside the ACA.<sup>152</sup> At one point there were other fleeting candidates for that role but the interest has now coalesced around health care reform done right, inside the ACA.<sup>153</sup>

Arkansas is the current leading contender,<sup>154</sup> though HHS's provisional approval of a premium support program, or privatized Medicaid expansion, will not really mean much until the financial terms of the plan are disclosed.<sup>155</sup> What is known is that "cost effectiveness" (the *sine qua non* of Medicaid premium support programs) may be in the eye of the beholder. This is especially significant in light of the phrasing of the most recent invitation to the states to apply for 1115 waivers. This invitation broadened the phrase "cost effectiveness" to both include consideration of the calculation of the cost of churning in the Medicaid eligible

---

150. See *Arizona Medicaid Waiver, Disability Services & Waivers*, MEDICAIDWAIVER.ORG, available at <http://medicaidwaiver.org/state/arizona.html> (last visited Nov. 14, 2013) (explaining that the Arizona Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), began in 1982 as a section 1115 Demonstration Waiver); see also Howard E. Freeman & Bradford L. Kirkman-Liff, *Health Care Under AHCCCS: An Examination of Arizona's Alternative to Medicaid*, HEALTH SERVS. RESEARCH 245, 246 (Aug. 1985) (describing Arizona's adoption of its Medicaid system).

151. See Freeman & Kirkman-Liff, *supra* note 150, at 245–46 (explaining Arizona's adoption of Medicaid as a result of its inability to maintain its system for administering medical care to the poor at the time).

152. See Ronald Brownstein, *Why the GOPs Resistance to Medicaid Expansion is Eroding*, NAT'L J. (Feb. 7, 2013), available at <http://www.nationaljournal.com/columns/political-connections/why-the-gop-s-resistance-to-medicaid-expansion-is-eroding-20130207> (noting that Republican Arizona Governor Jan Brewer is uncharacteristically pushing for an expansion of Medicaid under the ACA in order to receive more federal funding for providing health care to a large number of uninsured people, despite the "rocky" relationship between Governor Brewer and President Obama).

153. See, e.g., Trip Gabriel, *Medicaid Expansion is Set for Ohioans*, N.Y. TIMES, Oct. 21, 2013, at A12 (describing Republican Governor John Kasich's push to expand Medicaid in Ohio, despite his previous opposition to the ACA).

154. See, e.g., Gillian Mohny, *Arkansas Leads Way on Alternate Route for Medicaid Expansion*, ABC NEWS (Oct. 4, 2013), <http://abcnews.go.com/blogs/health/2013/10/04/arkansas-leads-way-on-alternate-route-for-medicaid-expansion/> (describing Arkansas's means of expanding the Medicaid program by using federal money to "purchase private insurance plans" for Medicaid participants).

155. See Letter from Marilyn Tavenner, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Andy Allison, Dir., Ark. Dep't of Human Servs. (Sept. 27, 2013) available at <http://posting.arktimes.com/media/pdf/arkansasassignedapprovaltr.pdf>.

population and include the cost reductions possible through increased competition.<sup>156</sup>

Whatever “cost effectiveness” turns out to mean, it will be of intense interest to try to calculate whether the value of the increased insured population in some state exchanges will enhance insurance rate competition and benefit all exchange purchasers, not just Medicaid premium funded purchasers. If the Congressional Budget Office is even close to accurate, it will cost the federal government \$6,000 a year to cover another individual American under Medicaid expansion but \$9,000 a year to cover the same individual under a Medicaid private option purchased commercial insurance plan<sup>157</sup> (with the wrap around coverage and premium subsidies necessary to make the commercial insurance “Medicaid-like”); there are going to be some interesting offset calculations ahead.

While much of our attention is directed at the federalism arena sparring between the states and the federal government,<sup>158</sup> not enough attention has been paid to the sparring between and among political units within the states over the Medicaid expansion. Consider California, for example. For several decades, California worked hard at unwinding its statewide safety net.<sup>159</sup> The full story would talk about county by county variable standards for public assistance, or the incredible inconsistency with which Medi-Cal applications were processed, but the real bottom line is the state’s forcing the counties to assume responsibility for medical indigents.<sup>160</sup> Seen from one perspective, California has perfected devolving the apparatus of the welfare state to the political unit closest to

156. See *Section 1115 Demonstrations*, MEDICAID.GOV (last accessed Nov. 16, 2013), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html> (describing the Section 1115 Waiver as a means for states to create experimental systems that “improve care, increase efficiency, and reduce costs”); see also Adrianna McIntyre, *Mediating Churn, Arkansas Edition*, PROJECT MILLENNIAL (July 4, 2013) <http://projectmillennial.org/2013/07/04/mediating-churn-arkansas-edition/> (identifying prevention of churning between coverage types as one of the intended consequences of Arkansas’s proposed 1115 waiver private option plan).

157. See Avik Roy, *CBO Guesstimates that the Supreme Court’s Impact on Obamacare is Modest*, FORBES.COM, THE APOTHECARY BLOG (July 24, 2012, 3:15 PM), <http://www.forbes.com/sites/aroy/2012/07/24/cbo-guesstimates-that-obamacare-will-cover-3-million-less-people-after-the-supreme-court-saving-84-billion/> (discussing the Congressional Budget Office’s estimates of how ACA costs will impact the deficit).

158. See, e.g., Scott L. Greer and Peter D. Jacobson, *Health Care Reform and Federalism*, 35 J. OF HEALTH POL., POL’Y, AND L. 203, 205 (2010) (developing criteria to determine whether the federal government or the states should lead health care reform).

159. See KIM BELSHE & SHANNON MCCONVILLE, PUB. POLICY INST. OF CAL., *RETHINKING THE STATE-LOCAL RELATIONSHIP: HEALTH CARE*, 7 (2013), available at [http://www.ppic.org/content/pubs/report/R\\_213KBR.pdf](http://www.ppic.org/content/pubs/report/R_213KBR.pdf). (discussing the evolution of California’s Health Care Safety Net Programs from 1966 to 1991).

160. See HEALTH ACCESS FOUND., *CALIFORNIA’S UNEVEN SAFETY NET: A SURVEY OF COUNTY HEALTH CARE 1–4* (2013), available at <http://www.health-access.org/files/expanding/California's%20Uneven%20Safety%20Net%20%20A%20Survey%20of%20County%20Health%20Care.pdf> (discussing how counties have “a highly variable patchwork of indigent care and safety-net programs and services” based on a county’s specific circumstances, demographics, politics, and resources).

community life. Seen from another perspective, unevenly burdened counties (particularly those with high populations of uninsured or undocumented Californians such as the 198,000 undocumented individuals living in San Diego County, roughly 6.5 percent of the total population)<sup>161</sup> stagger under county indigent expenses. This paradox only serves to emphasize the truism that California is simultaneously our richest state and our poorest state.<sup>162</sup>

This means that for Medicaid expansion to be funded in California, the counties will have to transfer money to the state.<sup>163</sup> Fearful of bankrolling Medicaid expansion for the working poor while still being left to serve the merely poor and definitively undocumented, the counties resisted.<sup>164</sup> In sum, this was the issue that Governor Jerry Brown negotiated with the counties in order to fund Medicaid expansion.<sup>165</sup>

### B. *What Will Happen on January 1, 2014?*

In some places, the bridge to January 1, 2014 is already being built – not just the obvious example of Massachusetts,<sup>166</sup> but in groups like the 500,000 early Medicaid beneficiaries enrolled in California.<sup>167</sup>

---

161. See Morgan Lee, *Estimated 198,000 Illegal Immigrants in SD County*, THE SAN DIEGO UNION-TRIBUNE (July 20, 2011, 3:10PM), <http://www.utsandiego.com/news/2011/Jul/20/estimated-198000-illegal-immigrants-in-sd-county/> (discussing the number of undocumented immigrants living in San Diego).

162. See DANIEL WEINTRAUB, CAL. HEALTH REPORT, CALIFORNIA IS RICHEST, POOREST STATE (2013), available at <http://www.healthycal.org/archives/12177> (discussing how California is home to more millionaires than any other state, but also “has the highest percentage of its population living below the poverty line.”); see also STEVEN P. WALLACE ET AL., UCLA CTR. FOR HEALTH POLICY RESEARCH, UNDOCUMENTED AND UNINSURED BARRIERS TO AFFORDABLE CARE FOR IMMIGRANT POPULATIONS 13 (2013), available at [http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Aug/1699\\_Wallace\\_undocumented\\_uninsured\\_barriers\\_immigrants\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Aug/1699_Wallace_undocumented_uninsured_barriers_immigrants_v2.pdf) (discussing how “undocumented immigrants will constitute a significant proportion of the remaining uninsured population and their concentration in a small number of states and localities places an uneven burden on the safety-net facilities in those areas.”).

163. See CAL. BUDGET PROJECT, EXPANDING HORIZONS: KEY FACTS ABOUT THE MEDI-CAL PROGRAM AS CALIFORNIA IMPLEMENTS HEALTH CARE REFORM 69 (2013), available at [http://www.cbpf.org/pdfs/2013/130402\\_Expanding\\_Horizons.pdf](http://www.cbpf.org/pdfs/2013/130402_Expanding_Horizons.pdf) (discussing how much of the county’s money should be redirected to the state, for purposes of Medi-Cal expansion).

164. See Chris Megerian, *Gov. Jerry Brown faces off with counties on California budget*, L.A. TIMES (May 29, 2013), <http://articles.latimes.com/2013/may/29/local/la-me-pc-jerry-brown-faces-off-with-counties-on-budget-20130529> (discussing how counties have resisted Governor Jerry Brown’s plans to make counties pay for a significant portion of Medicaid expansion costs).

165. See *id.* (discussing how Governor Jerry Brown’s plans are a part of the budget negotiations with counties).

166. See *Massachusetts Health Care Reform: Six Years Later*, KAISER FAMILY FOUND. 1, 2 (2012), available at <http://kff.org/health-costs/issue-brief/massachusetts-health-care-reform-six-years-later/> (discussing Massachusetts’ now seven-year-old experiment with state specific health care reform).

167. See ELIZABETH C. LYTLE ET AL., UCLA CTR. FOR HEALTH POLICY RESEARCH, PROMOTING ENROLLMENT OF LOW INCOME HEALTH PROGRAM PARTICIPANTS IN COVERED CALIFORNIA (2013), available at [http://laborcenter.berkeley.edu/healthcare/lihp\\_covered\\_](http://laborcenter.berkeley.edu/healthcare/lihp_covered_)

In October of 2013, the exchanges opened<sup>168</sup>—and in whatever forms they took—the navigators,<sup>169</sup> non-navigator assistance personnel,<sup>170</sup> and just about every other insurance counselor imaginable has experienced the biggest outpouring of those in need of insurance counseling we may ever see.<sup>171</sup> This is not a failure of the ACA in particular but more a function of American health insurance illiteracy.<sup>172</sup>

Confusion may mount when Medicaid expands in some places and not in others.<sup>173</sup> The American public is not aware that a mere state line may separate them from government-funded health insurance.<sup>174</sup> When this does begin to percolate into public consciousness, we will have a natural experiment in border effects. Little is known about how many Americans migrate to attain government-funded health insurance.<sup>175</sup> If there ever were a fact pattern to test that truism, we have found it.

---

ca13.pdf (discussing how “over 500,000 of the newly eligible individuals have enrolled in the [Low Income Health Program] since its inception in July of 2011 and will transition to Medi-Cal...”).

168. See *Open Enrollment Period*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/open-enrollment-period/> (last visited Nov.14, 2013) (noting the exchange’s open enrollment period, October 1, 2013 through March 31, 2014).

169. See *Navigator*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/navigator/> (last visited Nov.14, 2013) (defining a Navigator as “[a]n individual or organization that’s trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms.”).

170. See *In Person Assistance Personnel Program*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/in-person-assistance-personnel-program/> (last visited Nov.14, 2013) (describing non-navigator assistance personnel, also called in-person assistance personnel, as an “[i]ndividual or organizations that are trained and able to provide help to consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including helping them complete eligibility and enrollment forms.”).

171. See, e.g., Keith Collins et al., *Health Exchange Enrollment Falls Short of Target*, N.Y. TIMES, [http://www.nytimes.com/interactive/2013/10/04/us/opening-week-of-health-exchanges.html?\\_r=0](http://www.nytimes.com/interactive/2013/10/04/us/opening-week-of-health-exchanges.html?_r=0) (last updated Nov. 12, 2013) (displaying the number of consumers that enrolled in state exchanges and Medicaid in October).

172. See *Half of U.S. Adults Fail ‘Health Insurance 101,’ Misidentify Common Financial Terms in Plans*, AM. INST. OF CPAS (Aug. 27, 2013), <http://www.aicpa.org/press/pressreleases/2013/pages/us-adults-fail-health-insurance-101-aicpa-survey.aspx> (finding that the majority of Americans are not knowledgeable of financial terms in health insurance plans).

173. See Jane Bornemeier, *Survey Shows Confusion Over Health Care Law but Support for Medicaid Expansion*, N.Y. TIMES, (Sept. 30, 2013, 12:01 AM) <http://www.nytimes.com/news/affordable-care-act/2013/09/30/survey-shows-confusion-over-health-care-law-but-support-for-medicaid-expansion/> (noting eighty five percent of adults surveyed did not know their state’s decision on Medicaid expansion).

174. See generally GENEVIEVE KENNEY ET AL., URBAN INST., AWARENESS AND PERCEPTIONS OF MEDICAID AND SCHIP AMONG LOW-INCOME FAMILIES WITH UNINSURED CHILDREN: FINDINGS FROM 2001 (2004); GENEVIEVE KENNEY ET AL., VARIATION IN MEDICAID ELIGIBILITY AND PARTICIPATION AMONG ADULTS: IMPLICATIONS FOR THE AFFORDABLE CARE ACT (2012) (discussing health insurance program awareness levels in various states).

175. Though a certain amount has been revealed about the forced out-migration of some populations from one state to another with relatively richer government funded health insurance and health benefits. See John Cote, *Nevada Could Face Suit For Dumping Patients in California*, S.F. CHRONICLE (Aug. 20, 2013), available at <http://www.sfgate.com/news/article/S-F-sues->

The “Why Expand Medicaid?” question is widely discussed in state legislatures all over this country. The answer to that question ultimately depends on answers to a few under-discussed subsidiary questions: What is the problem that Medicaid seeks to fix? What does Medicaid do? What are the health consequences of Medicaid enrollment? What can we learn from the Oregon Medicaid Lottery and from the six jurisdiction-expanding Medicaid, that either re-enforces what we think we know about Medicaid or that challenges us in our thinking about Medicaid? Finally, will the ACA confront the Medicaid conundrum of rapidly increasing enrollment twinned with rapidly decreasing Medicaid reimbursement? Will Medicaid survive the ACA?

## V. THE DIFFERENCE OF MEDICAID

### A. *Has Medicaid Made Any Difference?*

Quantifying the benefits, if any, of health insurance and particularly government-funded health insurance is difficult. Perhaps the most over-theorized<sup>176</sup> but under-empiricized<sup>177</sup> topic in all of health law and policy analysis revolves around this difficult question. The answer to this freighted question colors perception on Medicaid expansion, just as perspective on the expansion of government-funded health insurance colors perception on the value of health insurance, in general, and government-funded health insurance, in particular.

Whether expanding Medicaid will improve access to health care and improve health outcomes is hotly debated.<sup>178</sup> A considerable part of the debate is over

---

Nevada-for-alleged-patient-dumping-4803450.php (last updated Sept. 12, 2013) (discussing allegations that Nevada forced 500 psychiatric patients of a state-run hospital to seek medical treatment in neighboring California); DAVID BAUGH AND SHINU VERGHESE, MATHEMATICA POLICY RESEARCH, MIGRATION PATTERNS FOR MEDICAID ENROLLEES, 2005–2007 57 (2012) (finding that, “[o]verall, only 3.7 percent of all Medicaid enrollees moved across states from 2005 through 2007.”).

176. See, e.g., Kenneth J. Arrow, *The Economics of Moral Hazard: Further Comment*, 58 AM. ECON. REV. 3, 537–539 (June 1968), available at <http://lingli.ccer.edu.cn/ahe2012/Week8/Arrow1968.pdf>.

177. Arguably, the Oregon Medicaid Lottery offers the first natural experiment in random assignment to Medicaid coverage needed to assess the benefits, if any, of health insurance since the RAND health insurance experiments of the 1970s. See generally AMY FINKELSTEIN ET AL., THE OREGON HEALTH INSURANCE EXPERIMENT: EVIDENCE FROM THE FIRST YEAR 1 (2011), available at <http://www.nber.org/papers/w17190.pdf> (discussing the Oregon Medicaid Lottery experiment and its first-year results). See also Amazing Fact! Science Proves Health Insurance Works: Ezra Klein, BLOOMBERG VIEW (July 6, 2011) <http://www.bloomberg.com/news/2011-07-07/amazing-science-proves-health-insurance-works-commentary-by-ezra-klein.html> (discussing Oregon’s Medicaid Lottery and the RAND health insurance experiments).

178. Compare Rachel L. Garfield & Anthony Damico, *Medicaid Expansion Under Health Reform May Increase Service Use And Improve Access for Low-Income Adults With Diabetes*, 31 HEALTH AFF. 159, 163 (2012), available at <http://content.healthaffairs.org/content/31/1/159.long> (exploring the link between ACA sponsored Medicaid expansion and improved access for diabetes treatment), with Megan McArdle & Avik Roy, *Why Obama’s Medicaid Expansion Will Reduce Health Care Access*, THE ATLANTIC (Mar. 9, 2012, 4:43 PM), <http://www.theatlantic.com/>

whether Medicaid enrollees – who often attain worse health outcomes than those enrolled in commercial health insurance,<sup>179</sup> and who sometimes have worse outcomes than those without any form of health insurance<sup>180</sup>—attain relatively poor health outcomes because of Medicaid.<sup>181</sup>

In short, we struggle to say whether it is the receipt of Medicaid itself or other variables, such as income levels, educational levels, or health literacy levels, that contribute to such poor health outcomes for the Medicaid population. This crucial question is at the center of a long simmering feud over whether expanding Medicaid actually reduces access to health care.<sup>182</sup> In order to understand this argument, it is necessary to understand Medicaid provider reimbursement.

Current Medicaid provider reimbursement is based on a system of administered pricing—part centralized fee schedule and part individually calibrated to the expenses of a particular provider.<sup>183</sup> Medicaid’s reimbursement rates, most importantly, are considerably lower than those of commercial health insurance<sup>184</sup> and of Medicare.<sup>185</sup> Medicaid’s reimbursement rates are set by the Medicaid participating rates, subject to final approval by the Secretary of HHS under a standard of whether the proposed rates are consistent with the purpose of the Medicaid statute.<sup>186</sup> The Secretary’s determination of the sufficiency of the state fee schedule, once made, is given great deference by the courts.<sup>187</sup>

---

business/archive/2012/03/why-obamacares-medicaid-expansion-will-reduce-health-care-access/254275/ (arguing that “patients on Medicaid... do far worse in health outcomes than do those in private insurance”).

179. See Devon Herrick & Linda Gorman, *Health Outcomes and Medicaid*, MACKINAC CENTER (June 21, 2013), <http://www.mackinac.org/18790> (discussing the health outcomes of Medicaid enrollees compared to those who are privately insured).

180. See *id.* (explaining that “academic researchers have found that Medicaid enrollees often fare worse than not only patients with private insurance, but also patients with no insurance . . .”).

181. See *id.* (discussing examples where Medicaid enrollees have experienced poor health outcomes because of Medicaid).

182. See Garfield & Damico *supra* note 178, at 163.

183. See ELICIA HERZ ET AL., CONG. RESEARCH SERV., RL32277, HOW MEDICAID WORKS: PROGRAM BASICS 33–35 (2005) (explaining that most states combine fee-for-service (paying a provider for a particular service based on state-established rates) and managed care (agreements to pay “fixed, prospective, monthly, per-person payment rates”) fee systems for delivering Medicaid services).

184. See Stephen Norton & Stephen Zuckerman, *Trends in Medicaid Physician Fees, 1993-1998*, 19 HEALTH AFF. 222, 227 (2000) (stating that Medicaid fees are lower than fees paid by private insurers since Medicaid reimbursement rates are lower than Medicare reimbursement rates, “which historically has had fees below those offered in private markets”).

185. See *id.* (explaining that Medicare fees paid are historically below the fees offered in private market).

186. See *Financing & Reimbursement*, MEDICAID.GOV, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Financing-and-Reimbursement.html> (last visited Nov. 22, 2013) (explaining that States establish their own rates within federal guidelines, which are subject to CMS review “for consistency with the Social Security Act and other federal statutes and regulations.”).

187. See *Douglas v. Indep. Living Ctr. of S. Cal.*, 132 U.S. 1204, 1210 (2012) (holding that since the agency has acted under its authority under the Medicaid Act and is an “expert in the

Few actual programs have tested whether the Medicaid fee schedule drives reduced health care access for Medicaid beneficiaries as well as the Oregon Medicaid Lottery.<sup>188</sup> For this reason, a closer look at the conception and operation of the Oregon Medicaid Lottery is an important part of understanding Medicaid's relationship, if any, to improved health status.

### 1. Oregon's Medicaid Lottery

Oregon's long history of experimentation and innovation in the Medicaid program reached its zenith with the creation of the Oregon Health Plan in the 1990's.<sup>189</sup> The brainchild of then state senator and now Governor John Kitzhaber, the Oregon Health Plan was explicitly designed to offer a thinner, limited, health insurance benefit<sup>190</sup> to the near poor or working poor.<sup>191</sup>

Using a federal Section 1115 Medicaid waiver,<sup>192</sup> Oregon expanded Medicaid's coverage to include a further 132,000 Oregonians by 1995,<sup>193</sup> including 120,000 new members in its first year<sup>194</sup> who were otherwise unable to afford commercial health insurance, but not formerly poor enough to qualify for Medicaid.<sup>195</sup> The business cycle turned and by 2004 Oregon no longer took new

---

statute's subject matter" and its "decision carries weight," "review of agency action requires courts to apply certain standards of deference to agency decision-making").

188. See *About the Study*, OR. HEALTH STUDY, <http://oregonhealthstudy.org/about-the-study/> (last visited Nov. 22, 2013) (describing how the Oregon Health Plan Lottery "created a once-in-a-lifetime opportunity to design a randomized controlled trial that measures the impact of health insurance.").

189. See Thomas Bodenheimer, *The Oregon Health Plan—Lessons for the Nation*, 337 NEW ENG. J. MED. 651, 651–52 (1997) (describing Oregon's success in implementing of the Oregon Health Plan, which added over 100,000 uninsured people to the Medicaid program while reducing the benefit package).

190. See OR. DEP'T OF HUMAN SERVS., OREGON HEALTH PLAN: AN HISTORICAL OVERVIEW 3, 15 (2006), available at <http://www.oregon.gov/oha/healthplan/DataReportsDocs/Oregon%20Health%20Plan%20-%20An%20historical%20overview.pdf> (stating that Senate President John Kitzhaber initiated the Oregon Medicaid Priority Setting Project, which led to the development of the Prioritized List of Health Services that made funding available for the Oregon Health Plan (OHP) to expand coverage to more individuals—this "Prioritized List" is a limited list of covered services, which placed more limits on health insurance benefits).

191. See *id.* at 1, 15 (explaining that OHP was formed to cover a limited "Prioritized List of Health Services" for an "expanded OHP population," of those who "didn't qualify for public assistance (Medicaid), were not insured by an employer, and couldn't afford individual coverage").

192. See Social Security Act, 42 U.S.C. 1315 (Supp. V 2006) (providing for waiver of state plan requirements particularly in "the case of any experimental, pilot, or demonstration project").

193. See Alan Katz, *The Oregon Health Insurance Lottery*, ALAN KATZ HEALTH CARE REFORM BLOG (Mar. 4, 2008), <http://alankatz.wordpress.com/2008/03/04/the-oregon-health-insurance-lottery/>.

194. See Joe Rojas-Burke, *How Federal Health Care Reform Will Affect People in Oregon*, OREGONIAN (Mar. 25, 2010), [http://www.oregonlive.com/health/index.ssf/2010/03/how\\_federal\\_health\\_care\\_reform.html](http://www.oregonlive.com/health/index.ssf/2010/03/how_federal_health_care_reform.html) (stating that "the Oregon Health Plan extended Medicaid coverage to 120,000 additional residents" in 1994).

195. See OREGON HEALTH PLAN: AN HISTORICAL OVERVIEW, *supra* note 190, at 1, 13 (explaining that OHP's purpose was to make health care available to thousands of people who did

enrollees in the Oregon Health Plan.<sup>196</sup> Expanding coverage—even limited coverage—in this way was extraordinarily expensive.<sup>197</sup> By 2008, Oregon’s uninsured numbers crept back to pre-Oregon Health Plan levels.<sup>198</sup> As spots opened in the continuing Oregon Health Plan, Oregon’s inventiveness in deciding how to allocate the scarce benefit was expressed in the decision to allocate 3,000 open spots by lottery.<sup>199</sup> Thus, the Oregon Health Insurance Lottery was born.

Oregon’s then 600,000 uninsured were invited to apply to enter a lottery for 10,000 open spots in the Oregon Health Plan.<sup>200</sup> More than 80,000 Oregonians chose to participate in the lottery.<sup>201</sup> The requirements for entry into the lottery were simply that one not previously be eligible for health insurance and that the applicant be “working age” – or between the ages of eighteen and sixty-five, have less than \$2,000 in assets, and have an income below the federal poverty line.<sup>202</sup> Not a great deal is known about the 80,000 lottery participants as compared with the total 600,000 uninsured.<sup>203</sup> It is a mistake to assume that the 80,000 lottery participants represented a cross-section of Oregon’s 2004 uninsured.<sup>204</sup> But it is fair to say that each lottery participant represents an individual who either thought

---

not qualify for Medicaid, even though their incomes were below the poverty line).

196. *See id.* at 10 (stating that “OHP Standard closed to new enrollment effective July 1, 2004”).

197. *See* Eric Fruits et al., *The Oregon Health Plan, A “Bold Experiment” That Failed*, CASCADE POLICY INST. 13 (2010) available at [http://cascadepolicy.org/wp-content/uploads/2010/09/Oregon\\_Health\\_Plan\\_-\\_The\\_Bold\\_Experiment\\_That\\_Failed.pdf](http://cascadepolicy.org/wp-content/uploads/2010/09/Oregon_Health_Plan_-_The_Bold_Experiment_That_Failed.pdf) (stating that under the OHP, demand for health insurance exceeded Oregon’s ability to pay, and discussing the failures of the OHP, including the program’s inability to maintain fiscal sustainability and control costs).

198. *See* Anne S. Kimbol, *Oregon’s Health Coverage Lottery – An Equitable Distribution Method or a Sign that We Have Given Up*, HEALTH LAW PERSPS. (2008), available at <http://www.law.uh.edu/healthlaw/perspectives/2008/%28AK%29%20Oregon.pdf> (stating that Oregon’s uninsured population was roughly 600,000 in 2008). When Oregon initiated the OHP, the state’s uninsured population was roughly 500,000. *See* JEANENE SMITH ET AL., OFFICE FOR OR. HEALTH POLICY AND RESEARCH, TRENDS IN OREGON’S HEALTHCARE MARKET AND THE OREGON HEALTH PLAN: A REPORT TO THE 74TH LEGISLATIVE ASSEMBLY 21 (2007), available at [http://www.oregon.gov/oha/OHPR/RSCH/docs/Trends/2007\\_LegisTrendsReport.pdf](http://www.oregon.gov/oha/OHPR/RSCH/docs/Trends/2007_LegisTrendsReport.pdf) (stating that when “Oregon initiated . . . the Oregon Health Plan . . . 18% of Oregon’s 2.85 million population was uninsured”).

199. *See id.* (describing the lottery systems as a reservation list for the newly available slots in the OHP opened during late January and through February of 2008 from which there were a few thousands slots to be filled by a lottery-style drawing).

200. *See id.* (explaining that Oregon developed a lottery system “[i]nstead of attempting to use tight eligibility requirements or a first-come-first-serve basis of allocating the new policies”).

201. *Id.*

202. *See id.* (discussing the OHP lottery eligibility requirements).

203. *See* Loren Heal, *Study of Oregon Medicaid Program Reveals No Significant Health Improvements*, HEARTLANDER (May 28, 2013), <http://news.heartland.org/newspaper-article/2013/05/28/study-oregon-medicaid-program-reveals-no-significant-health-improvement> (explaining that the study’s participants that “had self-selected to be on Medicaid by signing up for a waiting list . . . may differ as a group from people who were eligible but did not apply to be in the program” because those who participated in the lottery might have been “sicker or more interested in obtaining health care”).

204. *Id.*

they knew—or had an advocate who thought they knew—that enrollment in government-funded insurance is of value. This assumption that the acquisition of enrollment in The Oregon Health Plan would mean something good for the enrollee may be what distinguishes the population of lottery entrants from the rest of the uninsured; this was the first step in the pursuit of something of value.

This assumption deserves scrutiny precisely because it represents the self-selection of a group diametrically opposed to the idea that enrollment in government-funded health insurance is worse than no health insurance at all.<sup>205</sup> The Oregon lottery entrants, in short, were pre-disposed to believe that there would be a positive correlation between health insurance and health status; whether this was the product of previous episodes of enrollment in government-funded health insurance or the product of optimism bias or something else entirely is unclear. It is also uncertain whether individuals with pent up health needs were more likely to enroll in the lottery, potentially skewing the results about the relationship between lottery winners to enrollees seeking health care utilization in the early stages of enrollment. It is hard to say whether the lottery enrollees were seeking the peace of mind found in health insurance enrollment against inchoate future need, or whether they were pursuing coverage for a particular long-deferred procedure or treatment. Stated differently, we do not know if people seek government funded insurance for protection from the risk of financial devastation from serious illness or whether they seek government funded insurance to satisfy a particular health need. Understanding Medicaid beneficiary motivation would tell us something about utilization patterns as well as persistence of enrollment in government funded health insurance.

Even the degree of commitment between and among lottery participants was variable. A full 16,000 lottery participants had to be pulled out of the lottery to fill the 10,000 slots.<sup>206</sup> Some of those chosen were no longer eligible, some no longer alive, and some no longer reachable.<sup>207</sup> Low income individuals often lack the employment and housing stability that make follow up on months-earlier lottery enrollment easy.<sup>208</sup> A case could be made, as a result, that the lottery created a group of participants particularly motivated to achieve insured status and further

---

205. See generally Randall Olson, *Self-Selection Bias*, SAGE RESEARCH METHODS, <http://srmo.sagepub.com/view/encyclopedia-of-survey-research-methods/n526.xml> (last visited Nov. 15, 2013) (describing self-selection bias).

206. AMY FINKELSTEIN ET AL., WHAT IS THE LINK BETWEEN HAVING HEALTH INSURANCE AND ENJOYING BETTER HEALTH AND FINANCES? EARLY RESULTS OF THE OREGON HEALTH INSURANCE EXPERIMENT, ROBERT WOOD JOHNSON FOUND. 6 (2012), [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2012/rwjf72145](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf72145).

207. See *id.* at 10 (explaining why some individuals were no longer eligible to participate in the lottery).

208. See *Poverty, Housing Insecurity and Student Transiency in Rural Areas*, PENN STATE COLL. OF EDUC., <http://www.ed.psu.edu/educ/crec/research/poverty> (last visited Nov. 15 2013) (discussing the high frequency of residential mobility that households below the poverty level experience in comparison with the rest of the population).

focused that group to include those most likely to organize their lives in a way that enabled them to capitalize on insured status. Thus refined, the group that moved to Oregon Health Plan enrollment insured status was a collection of able-bodied, uninsured, low-income adults who affirmatively wanted health insurance.<sup>209</sup>

On a track roughly parallel to the winnowing of Oregon's uninsured to a group of 10,000 new Oregon Health Plan enrollees, Massachusetts Institute of Technology's Amy Finkelstein and her research group decided to study the new enrollees—both in the absolute and relative to a cohort of lottery losers.<sup>210</sup> Their questions: What does having Medicaid mean for health utilization and health outcomes for new enrollees and compared with the non-enrolled comparison group?<sup>211</sup> Is having Medicaid coverage better or worse than having no coverage at all?<sup>212</sup>

Evidence from the first year indicates that one year after enrollment, individuals both selected from Medicaid coverage and those who elected to pursue Medicaid coverage had better self-reported physical health, mental health, and access to care than those in the non-selected and non-enrolled control group.<sup>213</sup> Specifically, those in the lottery enrolled group were twenty-five percent more likely to report their health as good, very good or excellent and ten percent more likely to screen negative for depression.<sup>214</sup>

The improvement in self-reported health status came at a price. The lottery enrolled group increased their use of health care services, including increased probability of prescription drug use, preventive care use, and increased use of outpatient provider visits.<sup>215</sup>

Although the data is just beginning to become public, the Oregon Health Study Group's conclusions ignited a firestorm of debate about even early conclusions.<sup>216</sup> It may be that there has not been a randomized controlled experiment on the effect of insurance on health outcomes in several decades.<sup>217</sup> It

209. FINKELSTEIN ET AL., *supra* note 206, at 2.

210. *See id.* at 1–2 (explaining the statistical procedure used to evaluate the results of Oregon's health insurance experiment).

211. *See id.* at 1–2 (explaining the study's analysis is focused on the cost of increased health care utilization and benefits of health insurance on health).

212. *See id.* (explaining that the article compares those selected from the lottery with those that were not in order to estimate the impact of insurance coverage).

213. *See id.* at 3 (finding that one year after enrollment in the health program, those selected by the lottery have benefited from the coverage in comparison to those that were unable to apply for Medicaid).

214. *Id.* at 27.

215. *See id.* at 3 (finding that those selected by the lottery were more likely to take prescription drugs, utilize outpatient visits, and comply with recommended preventive care).

216. *See* Harold Pollack, *Oregon Medicaid Experiment "is a Rorschach test of people's views of the ACA"*, INCIDENTAL ECONOMIST (May 4, 2013, 8:00 AM), <http://theincidentaleconomist.com/wordpress/oregon-medicaid-experiment-is-a-rorschach-test-of-peoples-views-of-the-aca/> ("Wednesday's *New England Journal of Medicine* article on the Oregon Medicaid lottery has provoked a firestorm reaction").

217. *See* Aviva Aron-Dine et al., *The RAND Health Insurance Experiment, Three Decades*

may also be that the first year data from the Oregon Health Study Group questions some of the perceived wisdom of the RAND Corporation's Health Insurance Experiment (HIE).<sup>218</sup>

HIE's decades old conclusions have long been perceived wisdom.<sup>219</sup> Positions have hardened in light of the HIE study's conclusions.<sup>220</sup> Reputations have been made in reliance on the HIE study's conclusions.<sup>221</sup> And the HIE study's conclusion cemented philosophical perspectives into place.<sup>222</sup>

The Oregon Health Study Group's conclusions, as a result, are potentially disruptive. The lack of study on the empirical question of whether Medicaid expansion improves health status may be the least empiricized, but most highly theorized, question in all of health law and policy.

Compared to the uninsured control group, the Oregon Medicaid lottery enrolled received sixty percent more mammograms, twenty percent more cholesterol checks, forty-five percent more pap smears for women, thirty-five percent more outpatient care, and thirty percent more hospital based care.<sup>223</sup> The enrolled lottery winners chose to consume more health care, once they had lower out-of-pocket medical expenditures and medical debt,<sup>224</sup> just as the newly insured have long been tracked to bump up health care consumption.<sup>225</sup> And, even over the span of only one year, they self-reported better health—much of it attributable to better mental health.<sup>226</sup>

Though it is yet unclear whether the reported improved mental health status resulted from either or both improved health care access or reduced financial pressure from health care costs, it is remarkable how quickly improved mental health status was ruled by some as beyond the ken of improved health status.<sup>227</sup>

---

*Later*, 27 J. ECON. PERSPS 197, 198 n.1 (2013) (discussing the only two randomized health insurance experiments done in the United States since the RAND Health Insurance Experiment).

218. *See id.* at 220 (discussing RAND's rejection of the notion that medical spending "does not respond to out-of-pocket price").

219. *See id.* (discussing the solidification of the RAND experiment results "in the minds of a generation of health economists and policymakers").

220. *Id.*

221. *Id.*

222. *Id.*

223. FINKELSTEIN ET AL., *supra* note 206, at 3, 23.

224. *See id.* at 3 (discussing the results of those selected by the lottery after one year of enrollment).

225. *See* Daniel Polsky, *How the Newly Insured Use Health Services: a Lesson for the U.S. from Medicare*, 17 LDI ISSUE BRIEF (Jan. 2012), [http://ldihealtheconomist.com/media/how\\_the\\_newly\\_insured\\_use\\_health\\_services.pdf](http://ldihealtheconomist.com/media/how_the_newly_insured_use_health_services.pdf) (discussing the increase of health care consumption observed when previously uninsured individuals receive coverage under Medicare).

226. *See* FINKELSTEIN ET AL., *supra* note 206, 3–4 (finding that individuals enrolled in the Oregon Health Plan reported improvements in physical and mental health).

227. *Compare* Avik Roy, *Oregon Study: Medicaid 'Had No Significant Effect' On Health Outcomes vs. Being Uninsured*, FORBES.COM, THE APOTHECARY BLOG (May 2, 2013, 4:20 AM), <http://www.forbes.com/sites/theapothecary/2013/05/02/oregon-study-medicare-had-no-significant-effect-on-health-outcomes-vs-being-uninsured/> (discussing the significant increase in utilizing health care to diagnose and treat depression in Oregon's Medicaid experiment) *with*

Perhaps this is because mental health is notoriously difficult to quantify, sometimes not seen as health at all, and because the same self-reported improvements in depression might be attributable to the sheer force of income transfer, something that could be accomplished outside of expanded Medicaid.<sup>228</sup> In other words, it may be that Medicaid does improve health status, but so might other more cost effective interventions.<sup>229</sup>

### B. Will Medicaid Expansion Make Any Difference?

The immediate challenge before the states will be to determine whether Medicaid expansion under the ACA is gift or Trojan horse. This may take a while. The rollout of original Medicaid tells us this.<sup>230</sup> Although eleven states were all in on original Medicaid by 1967, New York was kicking around legislation that same year calling for Medicaid's repeal.<sup>231</sup> Still, eight more states were onboard by 1970, almost all participating within four years, though Arizona (the final hold out) was not onboard until 1982.<sup>232</sup> Texas considered exiting the Medicaid program as recently as 2010, but did not.<sup>233</sup>

---

Jonathan Cohn, *What Oregon Really Told Us About Medicaid*, NEW REPUBLIC, (May 13, 2012), <http://www.newrepublic.com/article/113195/oregon-medicaid-study-good-bad-and-ugly> (discussing the possibility that better mental health might be related to decreased stress over paying medical bills) and Marianne Udow-Phillips, *Oregon Medicaid study shows value of investment in mental health*, BRIDGE, (May 12, 2013), <http://bridgemi.com/2013/05/oregon-medicaid-study-shows-value-of-investment-in-mental-health/> (discussing how commentators have ignored the studies findings of improved mental health and have labeled the experiment as showing no significant health benefits).

228. See *Mental Health and Stress-Related Disorders*, NAT'L INST. OF ENVL. HEALTH SCIS., [http://www.niehs.nih.gov/research/programs/geh/climatechange/health\\_impacts/mental\\_health/](http://www.niehs.nih.gov/research/programs/geh/climatechange/health_impacts/mental_health/) (last visited Nov. 22, 2013) (discussing the difficulty in quantifying mental health concerns); Roy, *supra* note 227 (explaining the reported improvements in mental health and reduced financial strain).

229. See Roy, *supra* note 227 (arguing that although there is the possibility that Medicaid may show a benefit relative to those that are uninsured, there may be less expensive alternatives).

230. See OLSON, *supra* note 36.

231. *Id.*

232. *Id.*

233. TEXAS HEALTH AND HUMAN SERVS. COMM'N & TEXAS DEP'T OF INS., IMPACT ON TEXAS IF MEDICAID IS ELIMINATED 32 (Dec. 2010), [http://www.hhsc.state.tx.us/hb-497\\_122010.pdf](http://www.hhsc.state.tx.us/hb-497_122010.pdf) (weighing the costs and benefits of opting out of the Medicaid system). Of course, whether this latest decision by Texas not to exit Medicaid all together is the latest expression of Texan autonomy or the fullest expression of economic coercion is difficult to characterize after NFIB. See MUSUMECI, *supra* note 18, at 1 (reporting that Texas was one of twenty-five states to join a Florida lawsuit attempting to prohibit the government from coercing states to join in Medicaid expansion by withholding all federal Medicaid funding from states that failed to comply with expansion guidelines). The Supreme Court would eventually hold the federal government could withhold the Affordable Care Act Medicaid expansion funds from states failing to meet Medicaid expansion guidelines. *Id.* at 7.

Given Arizona Governor Janice Brewer's relative haste to be all-in on Medicaid expansion this time out of the gate,<sup>234</sup> there may be lessons to be learned from Arizona's journey to participation in original Medicaid.

1. *Arizona and the Cost of Uncompensated Care*

Arizona's interest in original Medicaid participation seems to have roughly correlated with the exponential growth in indigent care costs born by the state, rising from \$50 million in 1974 to \$125 million in 1980.<sup>235</sup> Although Arizona in the mid-1960s was insulated from the indigent care costs of some its poorest citizens because those same individuals were then eligible for free or reduced price care through the federally funded Indian Health Service,<sup>236</sup> these were significant numbers nonetheless.

Financial exigency, coupled with the argument that Arizonans were still taxed for the program in which they chose not to participate, seems to have ruled the day.<sup>237</sup> The history of original Medicaid buy-in thus strongly suggests that, eventually, the aversion to tax payment funding of benefits programs for citizens of other states may drive movement toward participation in ACA-expanded Medicaid. But these pressures dominate only at timescales of decades.

2. *The Chicken or the Egg: Medicaid and Health Outcomes*

Medicaid beneficiaries are, by definition, lower income individuals.<sup>238</sup> And they present Medicaid providers with all of the disproportionately complex health

---

234. See Ronald Brownstein, *Why the GOPs Resistance to Medicaid Expansion is Eroding*, NAT'L J. (Feb. 7, 2013), <http://www.nationaljournal.com/columns/political-connections/why-the-gop-s-resistance-to-medicaid-expansion-is-eroding-20130207> (noting Governor Jan Brewer's January of 2013 State of the State pronouncement that Arizona should join the ACA's expansion of Medicaid).

235. See Sarah Kliff, *Six Governors Say They Will Opt Out of Medicaid. How Long Will They Hold Out?*, WASH. POST (July 9, 2012), <http://www.washingtonpost.com/blogs/wonkblog/wp/2012/07/09/six-governors-say-they-will-opt-out-of-medicaid-how-long-will-they-hold-out/?print=1> (stating that Arizona was the final state to join Medicaid in 1982, and did so because of dramatic rise in cost of indigent health care).

236. Mark Trahant, *The Indian Health Service Paradox*, KAISER HEALTH NEWS (Sep. 16, 2009), <http://www.kaiserhealthnews.org/Columns/2009/September/091709Trahan.aspx> (stating the Indian Health Services was formed in 1955 with the primary mission of providing health care to Native American and Alaskan Natives).

237. See Suzy Khimm, *Will States Really Turn Down Federal Money? They've Done It Before*, WASH. POST (June 29, 2012), <http://www.washingtonpost.com/blogs/wonkblog/wp/2012/06/29/will-states-really-turn-down-federal-money-theyve-done-it-before/> (stating Arizona eventually adopted Medicaid due to rising health care costs, county government officials' anger with the state for failing to take advantage of federal health care funding, and critics calls that Arizona citizens were sending tax dollars to other states to subsidize health care without receiving any federal funding in return).

238. Medicaid and CHIP Payment and Access Commission, 42 U.S.C. § 1396a(a)(10)(A)(i) (Supp. 2013).

problems of lower income Americans.<sup>239</sup> More importantly, Medicaid beneficiaries present Medicaid providers with the fallout from all of the complex life problems that accompany low socio-economic status in the United States.<sup>240</sup>

The debate over whether Medicaid eligibility improves health status is really two intertwined debates. The first is over whether Medicaid eligibility improves health access.<sup>241</sup> The second is over whether improved health access via Medicaid improves health status.<sup>242</sup> Since the relationship between improved health access and health status is complex, it is important not to conflate them.<sup>243</sup> In short, these are both stories with supply and demand driven dimensions. How we understand them tells us something about how we conceive of the role of human agency and choice in health status.

### C. *Does Medicaid Eligibility Improve Health Access?*

Medicaid is the Rorschach test<sup>244</sup> of American health care politics. From one perspective, characterized as a broken, costly system in desperate need of reform, or even abolition, and from the other viewed as one of the more successful parts of the War on Poverty<sup>245</sup>—so successful that its expansion sits at the center of the ACA. The politics of Medicaid whipsaw between these two competing visions.

Although this article follows the popular usage of “Medicaid” as a universal moniker for the federal-state funded program of health insurance for the poor and the disabled, Medicaid is no absolute monolith.<sup>246</sup> In addition to representing fifty

239. See *Low Income Working Families Facts and Figures*, URBAN INST. 2 (Aug. 2005), <http://www.urban.org/UploadedPDF/900832.pdf> (finding that low-income working families are more likely to have health problems than middle-income families).

240. See R. J. Blendon, et al., *Medicaid Beneficiaries and Health Reform*, 12 HEALTH AFF. 132, 135 (1993) (finding many Medicaid beneficiaries have a difficult time affording the basic necessities for life, including food, clothing, shelter, and have serious concerns about being able to pay medical bills even with the assistance of Medicaid).

241. See Katherine Baicker & Amy Finkelstein, *The Effects of Medicaid Coverage – Learning From the Oregon Experiment*, 365 NEW ENG. J. MED. 683, 683 (2011) (stating there has been much debate over Medicaid because some believe “it pays providers so little that beneficiaries have trouble gaining access to care”).

242. See ECON. RESEARCH INITIATIVE ON THE UNINSURED, JUMPING TO CONCLUSIONS: WILL EXPANDING HEALTH CARE INSURANCE IMPROVE THE HEALTH OF THE UNINSURED? (Mar. 2003), <http://www.rwjf-eriu.org/pdf/research-highlight-mar.pdf> (stating hundreds of studies have demonstrated that people without health insurance face worse health outcomes, but questioning if that is enough to conclude that access to insurance would improve the health of the uninsured).

243. See, e.g., Katherine Baicker et al., *The Oregon Experiment – Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713, 1716 (2013) (finding Medicaid coverage did not significantly lower measures of blood pressure, cholesterol, glycosylated hemoglobin, or significantly reduce the risk of a cardiovascular event, such as heart attack or congestive heart failure).

244. See THE GALE ENCYCLOPEDIA OF PSYCHOLOGY 512 (Bonnie Ruth Strickland et al. eds., 2nd ed. 2003) (discussing the Rorschach Test, a projective test consisting of ten cards, each containing an inkblot, designed to allow subjects to interpret the inkblots in a way that gives insight into subjects personality).

245. OLSON, *supra* note 36.

246. LAURA SNYDER ET AL., KAISER FAMILY FOUND., KAISER COMMISSION ON MEDICAID

different variations, this program may also continue to draw distinctions between existing Medicaid beneficiaries and Medicaid expansion beneficiaries based on different coverage of U.S. Preventive Services Task Force A and B rated services.<sup>247</sup> When all the dust settles, previously enrolled Medicaid beneficiaries may have a different kind of Medicaid coverage from expansion Medicaid beneficiaries, in the realm of preventive services, for example.<sup>248</sup>

Similarly, implementation of Medicaid managed care is unevenly distributed throughout the country.<sup>249</sup> And the effectiveness of Medicaid managed care implementation varies throughout the country—dependent on finance, demographics, Medicaid oversight, the robustness of provider panels, and a state's experience in contracting with managed care entities.<sup>250</sup>

Even when painting with a broad brush, it is difficult to test whether Medicaid beneficiaries would be better off with no health insurance at all because few Medicaid beneficiaries seem likely to consent to uninsured status voluntarily. Medicaid beneficiaries, in short, appear to view Medicaid enrollment as something beneficial.<sup>251</sup> As a proxy calculation for the value of Medicaid enrollment, some

---

AND THE UNINSURED - WHY DOES MEDICAID SPENDING VARY ACROSS STATES: A CHART BOOK OF FACTORS DRIVING STATE SPENDING (2012), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8378.pdf> (stating that states have significant flexibility to expand Medicaid programs within their state, resulting in wide variations from state to state).

247. See Sara E. Wilensky & Elizabeth A. Gray, *Existing Medicaid Beneficiaries Left Off The Affordable Care Act's Prevention Bandwagon*, 32 HEALTH AFF. 1188, 1189 (2013) (stating that newly eligible Medicaid beneficiaries will be eligible for grade A and B services, while those currently enrolled in Medicaid will follow traditional Medicaid rules and may not be eligible for A and B rated services).

248. See Wilensky & Gray, *supra* note 247, at 1189 (stating that because the new health reform law treats the newly eligible and those already receiving Medicaid differently, it is possible that newly eligible beneficiaries may be eligible for different preventative services than those already receiving Medicaid).

249. See Robert Hurley & Stephen Zuckerman, *Medicaid Managed Care: State Flexibility in Action* 11–12 (Urban Inst., Mar. 2002) available at <http://www.urban.org/uploadedpdf/ACF1AAA.pdf> (noting that the extent to which states have implemented Medicaid managed care plans has been widely uneven, varying from states that have almost fully converted Medicaid into a pre-paid managed care plan, to other states which adopted very few managed care programs and still rely on the traditional Medicaid administrative structure).

250. Jenni Bergal, *Kentucky's Rush Into Medicaid Managed Care: A Cautionary Tale for Other States*, KAISER HEALTH NEWS (July 15, 2013), <http://www.kaiserhealthnews.org/stories/2013/july/14/kentucky-medicad-managed-care.aspx?referrer=search> (reporting that patients in Kentucky have experienced problems since the state switched to a managed care plan). Debra Lipson, a senior researcher at Mathematica Policy Research, stated, "The Kentucky case is a harbinger of what can happen when states don't allow enough time and devote sufficient resources to strengthen the Medicaid agency's oversight capacity and systems—or develop strong contracts and care monitoring systems from scratch if they haven't contracted with managed care plans before." *Id.*

251. See DANIELLE YOUNG ET AL., CTR. FOR HEALTH CARE RESEARCH & TRANSFORMATION, COVER MICHIGAN SURVEY 2013: SATISFACTION WITH HEALTH CARE COVERAGE 2 (2013) (finding that survey recipients of Medicaid were the most satisfied of any group of insurance recipients surveyed, and the most concerned of any group with losing their benefits).

have compared Medicaid beneficiary health status with the health status of the non-Medicaid enrolled uninsured.<sup>252</sup> The trouble with this is that the studies do not, and cannot, account for the possible pre-disposition of the sickest uninsured to seek out Medicaid enrollment.<sup>253</sup> It is hard to factor in the likelihood that the Medicaid population may be sicker than the general uninsured population or, phrased differently, that the sicker subset of the uninsured population may be the most motivated and persistent seekers of Medicaid enrollment.<sup>254</sup> Even adjusting for severity mix, it is hard to know how much adjustment for severity mix is appropriate when comparing Medicaid enrolled and uninsured populations.<sup>255</sup>

If the uninsured are better off than Medicaid beneficiaries, after all, we would have to explain exactly why we have Medicaid. If expanding Medicaid reduces access to health care<sup>256</sup> we would have to explain why we have non-expansion or original Medicaid. And if the uninsured are better off than Medicaid beneficiaries, we would have to explain why we do not dedicate valuable government funding to duplicating for the Medicaid population those identifiable things that make the uninsured better off, such as better access to health care charity care. What Aaron Carroll and Harold Pollack have described as the “wide . . . debate over whether Medicaid helps or hurts its own recipients”<sup>257</sup> continues—in expanded format – in the states still debating ACA Medicaid expansion<sup>258</sup> but with an even greater

252. See John Holahan, *Health Status and the Cost of Expanding Insurance Coverage*, 20 HEALTH AFF. 279, 280 (2001) (studying the differences in health status between those on Medicaid and the uninsured).

253. See Jonathan Cohn, *Attention Conservatives: Yes, Medicaid Works*, NEW REPUBLIC (July 7, 2011), <http://www.newrepublic.com/blog/jonathan-cohn/91538/medicaid-works-health-oregon-lottery-finkelstein-gruber-newhouse#> (stating that when comparing people with Medicaid to people without insurance there is no way to account for differences between the populations, such as whether people suffering from a major medical condition are more likely to sign up for public insurance rather than remain uninsured).

254. See Austin Frakt et al., *Our Flawed but Beneficial Medicaid Program*, 364 NEW ENG. J. MED. e31(1), e31(2) (April 21, 2011) (stating that Medicaid beneficiaries are, as a whole, sicker, poorer, and with less access to resources when compared against the uninsured).

255. See Baicker & Finkelstein, *supra* note 241, at 683 (noting it is difficult to compare Medicaid enrollees against the uninsured because of the many differences between the two groups, including baseline health status).

256. See Avik Roy, *New Study: Expanding Medicaid Reduces Access to Health Care*, FORBES.COM, THE APOTHECARY BLOG (Mar. 10, 2012, 6:57 PM), <http://www.forbes.com/sites/aroy/2012/03/10/new-study-expanding-medicicaid-reduces-access-to-health-care/> (describing various studies demonstrating that the ACA’s Medicaid expansion has the potential to reduce access to physicians).

257. Aaron Carroll & Harold Pollack, *Expanding Medicaid saved lives*, THE INCIDENTAL ECONOMIST (July 26, 2012, 8:28 AM), <http://theincidentaleconomist.com/wordpress/expanding-medicicaid-saved-lives/>.

258. See *id.* (discussing how a number of states have recently used the “questionable” quality of Medicaid to fortify their arguments against expansion); see also *State Participation in the Affordable Care Act’s Expansion of Medicaid Eligibility*, COMMONWEALTH FUND (July 2013), <http://www.commonwealthfund.org/Maps-and-Data/Medicaid-Expansion-Map.aspx> (identifying states that may have a continuing debate about Medicaid expansion as evidenced by their rejection of the ACA Medicaid expansion plan).

urgency.<sup>259</sup> After all, if Medicaid hurts its own recipients, subsidized exchange purchased health insurance will do the same.<sup>260</sup> Should all non-open market purchased health insurance—even if purchased at commercial market rates in a structured commercial market place—be inherently suspect as bad for the health outcome enrollees? If so, we must consider whether it is the nature of the enrollees or the nature of the utilization of non-market acquired coverage or something else entirely that makes it suspect.

The striking thing about these debates is they are both old and new again, as well as for how they occur in an apparent vacuum.<sup>261</sup> We have been expanding Medicaid incrementally for decades,<sup>262</sup> however, and should be able to learn some things from the morbidity and mortality data surrounding these earlier expansions.<sup>263</sup> Sommers, Baicker, and Epstein have compared all-cause mortality rates of working-age childless adults between 2000 and 2005 in three states—Arizona, Maine, and New York—with these same states before and after expansion as well comparison non-expansion states.<sup>264</sup> Estimating a 6.1 percent reduction in relative risk of death among adults,<sup>265</sup> the authors note an estimated reduced mortality risk in line with population-level reductions in infant and child mortality associated with Medicaid expansions involving these populations in the 1980s.<sup>266</sup>

---

259. See Noam N. Levey, *Medicaid Has Mixed Record On Improving Health For Poor*, *Study Says*, L.A. TIMES, May 1, 2013, <http://articles.latimes.com/2013/may/01/news/la-pn-medicaid-mixed-record-improving-health-20130501> (“The Medicaid debate has taken on new urgency as the Obama administration pushes states to take advantage of the 2010 Affordable Care Act”).

260. This is more than a rhetorical question because it addresses the problem of moral hazard as well as the reality that high-deductible health insurance, structured to discourage use of health care, may be affirmatively harmful to the health of the insured. See Walecia Konrad, *The Many Hidden Costs of High-Deductible Health Insurance*, N.Y. TIMES (May 30, 2009), <http://www.nytimes.com/2009/05/30/health/30patient.html> (explaining how beneficiaries with low incomes are discouraged from using their health insurance because they cannot afford the high cost-sharing requirements that must be met before the insurance begins sharing or covering the cost of services).

261. See, e.g., Dayna Bowen Matthew, *The “New Federalism” Approach to Medicaid: Empirical Evidence That Ceding Inherently Federal Authority to the States Harms Public Health*, 90 KY. L.J. 973, 976–78, 996–98 (2001-2002) (discussing the Bush administration’s new Medicaid rules giving more power to the states to control their Medicaid programs and the possible reduction in access to health care for beneficiaries as a result).

262. See *Medicaid’s Milestones*, CTRS. FOR MEDICARE AND MEDICAID SERVS., available at <http://www.cms.gov/About-CMS/Agency-Information/History/index.html?redirect=/History/> (last visited Nov. 12, 2013) (showing a timeline of amendments and expansions to Medicaid since its enactment in 1965).

263. See Benjamin D. Sommers, et al., *Mortality and Access to Care among Adults After State Medicaid Expansions*, 367 NEW ENG. J. MED. 11, 1032–34 (Sept. 13, 2012) (discussing the findings of a study that examined the mortality rates in states with expanded Medicaid, finding that expansion was associated with reduced mortality as well as improved health care coverage, access to care, and self-reported health).

264. See *id.* at 1026 (comparing these three states with neighboring states, selected as “controls”, which did not have Medicaid expansion).

265. *Id.* at 1028.

266. *Id.* at 1026.

The costs of earlier Medicaid expansions for children and pregnant women could even be estimated and extrapolated to current dollars.<sup>267</sup>

In light of the paucity of data on the actual health effects of Medicaid enrollment, the rhetorical certainty on both sides is surprising. The assertion that “Republican governors who have refused the expansion know full well that they are . . . hurting their own low-income residents”<sup>268</sup> as well as its polar opposite claim that “physicians even do better caring for the uninsured than they do caring for Medicaid patients”<sup>269</sup> both assume what is not known at present. Given the paucity of actual research on the question of the actual health effects of Medicaid enrollment, it is difficult to assess the veracity of either assertion. Effects on depression and family income aside, there have not been the kinds of studies to produce definitive answers to these questions.

#### D. Does Medicaid Coverage Improve Health Access?

Even the fundamental question of whether Medicaid enrollment improves health care access is really two-dimensional. Enrollment may improve access to Medicaid, as well as improve access to providers. The relationship between Medicaid enrollment and access is tricky both because enrollment is not the same as utilization and because Medicaid take-up rates are notoriously difficult to predict.<sup>270</sup> A number of Medicaid enrollees do not use eligibility in any kind of comprehensive way.<sup>271</sup> Whether this is because of lack of access to providers or preference to reserve Medicaid eligibility for catastrophic health care coverage alone is, in and of itself, hard to project. What is known is that a percentage of Medicaid beneficiaries also use other forms of access to indigent health care, and that a percentage of individuals using other forms of indigent health are potentially eligible for Medicaid enrollment.<sup>272</sup> It is also significant that some distinct groups

267. See Carroll & Pollack, *supra* note 257 (discussing a study analyzing the health impacts and costs associated with earlier Medicaid expansion and expressing these findings in 2012 dollars).

268. David Firestone, *Rick Scott Accepts Reality*, TAKING NOTE, N.Y. TIMES (Feb. 21, 2013, 1:47 PM), <http://takingnote.blogs.nytimes.com/2013/02/21/rick-scott-accepts-reality/>.

269. Roy, *supra* note 256.

270. See Chapin White, *A Comparison of Two Approaches to Increasing Access to Care: Expanding Coverage versus Increasing Physician Fees*, 47 HEALTH SERVS. RESEARCH 963, 979 (2012) (finding that coverage expansion does not necessarily mean an increase or decrease in utilization); see also Ben Sommers et al., *Understanding Participation Rates in Medicaid: Implications for the Affordable Care Act*, U.S. DEP’T OF HEALTH & HUMAN SERVS., HHS OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION ISSUE BRIEF (Mar. 2012), <http://aspe.hhs.gov/health/reports/2012/medicaidtakeup/ib.shtm> (discussing the many variables that effect calculating “take-up” rates).

271. See *Medicaid in Colorado: How Enrollees Access and Use Health Care*, THE COLORADO TRUST 5–6, 8 (Jan. 2013), [http://www.cohealthaccesssurvey.org/wp-content/uploads/2013/01/CHAS\\_MedicaidBrief\\_v.pdf](http://www.cohealthaccesssurvey.org/wp-content/uploads/2013/01/CHAS_MedicaidBrief_v.pdf) (discussing how fourteen percent of Medicaid enrollees, double that of those commercially insured, reported that they did not see doctors for needed care because of cost).

272. See *id.* at 3–4 (discussing where Medicaid beneficiaries receive care, other than at

of pregnant women are or will be eligible for either or both Medicaid and commercial insurance purchased through the exchange in their state, primarily because pregnancy-related Medicaid coverage is excluded from the definition of minimum essential coverage.<sup>273</sup>

Physician acceptance of new Medicaid patients varies.<sup>274</sup> In California, for example, Medi-Cal beneficiaries are nearly twice as likely as other insured adults to report difficulty in obtaining an outpatient doctor's appointment.<sup>275</sup> This difficulty is consistent across specialty physician outpatient appointments, as well as primary care providers.<sup>276</sup> Federal Medicare guidelines attempt to forestall this by advising a ratio of sixty to eighty primary care providers for every 100,000 Medi-Cal beneficiaries.<sup>277</sup> A 2010 retrospective study at Californian physician participation in Medi-Cal tallied fifty primary care providers for every 100,000 Medi-Cal beneficiaries.<sup>278</sup> The irony of the least sophisticated health care consumers being called upon to demonstrate a fairly high level of operational sophistication in gaining access to our health care system is not lost on enrollees as well as observers.<sup>279</sup>

---

traditional physician offices, and explaining that Colorado has the opportunity, through the Affordable Care Act, to expand Medicaid to everyone in Colorado who is at or below 133% of the federal poverty level); see also Genevieve M. Kenney, *Variation in Medicaid Eligibility and Participation among Adults: Implications for the Affordable Care Act*, 49 *Inquiry* 3 231, 236 (2012) (explaining that out of 39 million uninsured nonelderly adults, 11.5 percent, or 4.5 million, were eligible for comprehensive Medicaid benefits but not enrolled).

273. Department of the Treasury rules exclude coverage under 42 U.S.C. § 1396a(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) from the definition of minimum essential coverage. 78 *Fed. Reg.* at 53,658. The rules would appropriately permit a pregnant woman receiving coverage under 42 U.S.C. § 1396a(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) to take advantage of APTCs to purchase comprehensive health care coverage through a Marketplace, if she so desired.

274. NAT'L CTR. FOR HEALTH STATISTICS, *supra* note 72, at 2.

275. See CAL. HEALTHCARE FOUND., *MEDI-CAL AT CROSSROADS: WHAT ENROLLEES SAY ABOUT THE PROGRAM* 15 (2012), available at <http://www.chcf.org/publications/2012/05/medical-crossroads-what-enrollees-say> (examining self-reported data from Medi-Cal beneficiaries showing increased difficulty compared to those with private insurance in obtaining out-patient appointments with primary care physicians and specialists).

276. *Id.* at 11, 15. 42% of those enrolled in Medi-Cal reported difficulty obtaining an appointment with a specialist, compared to 24% of those reporting difficulty who have other coverage. *Id.* Additionally, 26% of Medi-Cal enrollees reported similar difficulty seeing a primary care provider, as compared to 15% of those reporting difficulty who have other coverage. *Id.*

277. See ANDREW B. BINDMAN ET AL., *PHYSICIAN PARTICIPATION IN MEDI-CAL*, 2008, CAL. HEALTHCARE FOUND. 10 (July 2010), available at <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20PhysicianParticipationMediCal2008.pdf> (explaining that the Health Resources and Services Administration established that Medicaid programs should provide 60-80 primary care providers per 100,000 Medicaid beneficiaries).

278. *Id.*

279. See Patricia A. Post, *Casualties of Complexity: Why Eligible Homeless People Are Not Enrolled in Medicaid*, NAT'L HEALTH CARE FOR THE HOMELESS COUNCIL 4 (May 2001), <http://www.nhchc.org/wp-content/uploads/2011/10/Casualties-of-Complexity.pdf> ("The great irony is that in many states, the Medicaid program has become so fragmented and elaborate that many of the people for whom it was intended . . . are unable to negotiate the application and enrollment process").

Physician acceptance of new Medicaid patients also correlates with the existence of an infrastructure necessary to process claims paperwork.<sup>280</sup> In Missouri, for example, perceived administrative burdens associated with Medicaid participation are particularly acutely felt among sole or small group practices.<sup>281</sup> It may be the culture of “deny first” combined with the low reimbursement rate that turns providers away from Medicaid participation.<sup>282</sup>

Lack of health care access is a particularly pronounced problem in rural settings. And the smaller scale of health care delivery makes Medicaid participation more difficult both for providers and beneficiaries. Rural Missouri residents are poorer than metropolitan residents.<sup>283</sup> And rural physicians in Missouri are both older than metropolitan physicians<sup>284</sup> and practice in smaller group settings.<sup>285</sup> Rural Missouri residents are also disproportionately represented among the uninsured and the low income uninsured.<sup>286</sup> Nowhere more than in Missouri’s rural areas, do the great demographic forces of modern American health care collide: individuals with lower income and worse health status experience a shortage of providers in general and providers, in particular, who are equipped to accept Medicaid on the scale contemplated by the Medicaid expansion provisions of the ACA.<sup>287</sup>

Perhaps the strongest demonstration of this irony is found in the ACA’s determination to compensate Medicaid participating primary care providers at a higher rate at Medicare parity in 2013 and 2014—instead of at the more typical percentage of Medicare.<sup>288</sup> Federalizing primary care provider compensation under Medicaid, even if only for a two year trial period, provides an opportunity to test

---

280. *See* MO. FOUND. FOR HEALTH AND THE HEALTH CARE FOUND. OF GREATER KAN. CITY, *supra* note 115, at 7 (explaining that larger practice settings are more likely to accept Medicaid patient because they can see larger volumes of patients which helps offset the lower reimbursement rates and claims paper work).

281. *See id.* at 7 (explaining that sole or small group physicians operate on small margins and the administrative burden of Medicaid may be a disincentive).

282. *See id.* (explaining that some states have fee-for-service systems that require the Medicaid program to “deny first” when processing claims).

283. *See* MO. HOSP. ASS’N, PRIMARY CARE PHYSICIANS: THE STATUS IN RURAL MISSOURI 1 (2011), available at [http://www.missourihealthmatters.com/wp-content/uploads/2011/07/072711\\_Physician-Workforce-Report.pdf](http://www.missourihealthmatters.com/wp-content/uploads/2011/07/072711_Physician-Workforce-Report.pdf) (noting that approximately 5% more rural residents than metropolitan residents in Missouri live in poverty).

284. *See id.* at 4 (“In Missouri, 55 percent of all physicians are 50 or older. Yet, the percentage of rural physicians 50 and older jumps to 62 percent.”).

285. *Id.* (explaining that the ratio of primary care physicians to residents is much lower in rural Missouri than in the state’s metropolitan areas).

286. *See* KEITH J. MUELLER ET AL., MEDICAID AND ITS IMPORTANCE TO RURAL HEALTH 4 (2007), available at <http://www.rupri.org/Forms/IssueBrief.pdf> (describing the economic benefits of Medicaid in rural America, including sustaining rural primary care practices in areas disproportionately populated by people without health insurance).

287. *See* MO. HOSP. ASS’N, *supra* note 282, at 4, 7 (explaining that rural Missouri has fewer primary care physicians per citizen than metropolitan Missouri, and that, for example, a lack of specialists strains primary care physicians’ ability to take on new Medicaid patients).

288. 42 U.S.C. 1396a(a)(13)(C) (Supp. V 2006).

whether primary care providers shirk Medicaid beneficiaries solely because of Medicaid reimbursement concerns or because of other related and un-related concerns.

*E. Does Medicaid Coverage Improve Health Outcomes?*

The contention that Medicaid expansion may actually reduce access to health care relies on data indicating better health outcomes for those without insurance or those with commercial insurance.<sup>289</sup> The implication is that more doctors are willing to see the uninsured rather than the Medicaid insured because seeing the latter will force them to “go broke.”<sup>290</sup> In fact, this is true because some of the uninsured pay out of pocket.<sup>291</sup> Not only do providers not “go broke” seeing these individuals, they may well represent the single highest paying group in any particular payer mix.<sup>292</sup> While correct in the pronouncement that “health insurance is not the same thing as health care”<sup>293</sup> the analysis is incomplete in failing to estimate whether better Medicaid reimbursement vis-à-vis commercial insurance might not be the root cause and for the assumption that it cannot be remedied.

Increased Medicaid reimbursement rates should not be so far beyond health care organization ken—despite their presence in the ACA itself—that they are not even considered.

*1. Does Health Insurance From Any Source Improve Health Status?*

The downside to health insurance expansion has long been acknowledged as the problem of moral hazard.<sup>294</sup> The same health insurance expansion that generally makes health insurance cheaper may also promote over-consumption of

---

289. Roy, *supra* note 256 (describing studies showing that Medicaid patients have worse health outcomes than patients with private insurance and no insurance).

290. *See id.* (explaining Medicaid reimburses doctors below the cost of treating Medicaid patients).

291. *See id.* (explaining that many uninsured individuals pay for health care out of pocket). Seen from this perspective, “uninsured” is an umbrella term for disparate groups: the voluntarily uninsured, the involuntarily uninsured, those able to pay out of pocket for health care services, and those unable to do so. *See* JUNE E. O’NEILL & DAVE M. O’NEILL, EMP’T POLICIES INST., WHO ARE THE UNINSURED?: AN ANALYSIS OF AMERICA’S UNINSURED POPULATION, THEIR CHARACTERISTICS AND THEIR HEALTH 5, 20 (2009) *available at* [http://www.epionline.org/studies/oneill\\_06-2009.pdf](http://www.epionline.org/studies/oneill_06-2009.pdf) (defining voluntarily uninsured, involuntarily uninsured, those able to pay out of pocket for health care services, and those unable to pay for health care services).

292. *See* Steven Brill, *Bitter Pill: Why Medical Bills Are Killing Us*, TIME (Mar. 4, 2013) (explaining that hospitals set their rates at “chargemaster” prices, marked up as much as over one hundred times the actual cost, and discount that initial rate for private and public insurers, but not for the uninsured who end up paying more).

293. *See* Roy, *supra* note 256.

294. *See* Katherine Baicker, et al., *Behavioral Hazard in Health Insurance 2* (Nat’l Bureau of Econ. Research, Working Paper No. 18468, 2012), *available at* <http://www.nber.org/papers/w18468.pdf> (stating that subsidizing health care creates the moral hazard of overutilization).

health care services.<sup>295</sup> Health insurance, seen from this perspective, may promote inefficient overuse if it functions to lower cost to the consumer to the point of total or near total insulation from the price to insurer or the cost of production of health care by providers.<sup>296</sup>

There has been some research documenting that health care consumers are price sensitive, and that this price sensitivity drives some overuse of health care.<sup>297</sup> And there has been some research documenting consumer price sensitivity driven underutilization of health benefits.<sup>298</sup> These are also characterized as inefficiencies because such underutilization is often of some of the most cost effective interventions in health care—things like failing to uniformly and consistently use beta blockers to fight heart disease.<sup>299</sup>

Even as this article goes to press, a new study on the relationship between the Massachusetts state specific health care reform's expansion of insurance and its same period mortality data reignites the debate about whether the Massachusetts decline in mortality by three percent percentage points in the first four years of reform can tell us anything about the implications of improved access elsewhere in the United States.<sup>300</sup>

## VI. CONCLUSION

The Medicaid expansion that emerged from the Supreme Court, tempered by the implementation-altered optional Medicaid expansion going on all around us certainly demonstrates that Medicaid expansion itself may not survive National Federation. But pre-ACA expansion appears to be intact. No state, however ambivalent about the ACA's expansion of Medicaid, is proposing to throw in the towel on Medicaid altogether.<sup>301</sup> If the re-invention of expanded Medicaid is allowed to bleed over into using pre-expansion Medicaid as a funding mechanism—creating another class of Medicaid distinct from pre-expansion Medicaid—it may be that Medicaid as we know it today, in non-Bridge to

---

295. *See id.* (“[S]ubsidizing health care causes people to use too much of it.”).

296. *See id.* (stating that overutilization of health care results from pricing it below cost).

297. *See* RAND HEALTH, THE HEALTH INSURANCE EXPERIMENT: A CLASSIC RAND STUDY SPEAKS TO THE CURRENT HEALTH CARE REFORM DEBATE 2 (2006), available at [http://www.rand.org/content/dam/rand/pubs/research\\_briefs/2006/RAND\\_RB9174.pdf](http://www.rand.org/content/dam/rand/pubs/research_briefs/2006/RAND_RB9174.pdf) (explaining that patients without cost sharing obligations tend to use more health care services than those with cost sharing).

298. *See* Baicker et al., *supra* note 293, at 2 (describing the inefficiency of underusing highly beneficial health care).

299. *See id.* (explaining that people often underuse such cost-effective interventions as beta blockers, HIV drugs, antibiotics for tuberculosis, Medicaid-covered prenatal care, and post-organ transplant immunosuppressants).

300. Benjamin D. Sommers et al, *Changes in Mortality After Massachusetts Health Care Reform: A Quasi-Experimental Study*, 160 ANN. INTERNAL MED. 585, 593 (2014).

301. *See Medicaid*, NAT'L CONFERENCE OF STATE LEGISLATURES, <http://www.ncsl.org/issues-research/health/medicaid-home-page.aspx> (last visited Nov. 16, 2013) (stating that every state in the United States continues to participate in pre-ACA Medicaid).

Expansion states, will fail.<sup>302</sup> Further polarizing the interests of the core Medicaid beneficiaries or the poor from the interests of the re-invented expansion Medicaid beneficiaries or the working poor may end any effort to bring Medicaid into the mainstream.<sup>303</sup>

In summary, the complex evolution of Medicaid going forward, framed as one big Medicaid gamble, produced an almost infinite number of side bets that distort our view of the original.<sup>304</sup> The future of Medicaid—almost Byzantine in its current complexity—is destined to be even more multiple and varied.<sup>305</sup> The original gamble that Medicaid would be federalized devolved into a situation where individual stakeholders will build their own Medicaid programs even more tailored to their hopes and fears.<sup>306</sup>

---

302. *See supra* Parts III.C.1, IV.A.1 (describing the legal contentiousness and potential unsustainability of maintaining low Medicaid reimbursement rates for Medicaid expansion as well as the high cost of funding “Medicaid-like” programs).

303. *See supra* Part IV.A (explaining that the fundamental social and economic ambivalence toward the poor in the United States produces public resistance to Medicaid itself).

304. *See supra* Part I (describing the many kinds and instances of gambles underlying Medicaid reform that manifest ACA implementation as a splintered and complicated mess rather than the unified expansion of Medicaid envisioned by the ACA’s framers).

305. *See supra* text accompanying notes 192–94 (describing the increased complexity and confusion that will result when states implement their varied Medicaid expansion plans).

306. *See supra* pp. 57–59.