

The 2014 Elections and the Future of Medicaid



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Background

The 2014 midterm elections saw significant Republican gains in both the US Congress, where control of the Senate changed hands, and in state houses across the country. These changes may well impact Medicaid in a variety of ways moving forward, but in themselves, are not likely to significantly alter the course of the program.

Medicaid was an enormously important, and at times, controversial, program well before the Affordable Care Act (ACA) made it more important and more controversial. Even prior to the ACA's expansion of the program in 2014, Medicaid covered more than 72 million Americans and spent more than \$400 billion per year. Even before the ACA became known as "Obamacare," Medicaid was often in the political cross hairs, as states debated how best to administer a program that represented 25% of their entire budget, and as federal lawmakers often had similar conversations about the fate of the program.

State Perspectives on the Medicaid Expansion Decision

The Supreme Court's landmark decision to declare the ACA's mandatory Medicaid expansion to include all Americans up to 138% of the federal poverty level (FPL) unconstitutional, turned a key component of the law upside down and empowered states to make the decision for themselves whether or not to expand the program. It was also deeply ironic that prior to the Roberts court decision, few Americans (or even policy makers) even knew that Medicaid was such a prominent component of the ACA, actually accounting for approximately half of the \$1 trillion spending total of the whole law.

The first activity many states undertook in the wake of the Court's decision was to explore the nature of this new option. Could states pick and choose a variety of different aspects of the expansion, or could they perhaps do a partial expansion (up to 100% of the FPL was a common request, given that Exchange subsidies could be available to all Americans above that level)? Unfortunately for many states, the administration quickly stepped in to tell states that their choice was in fact binary—they could do it as envisioned in the law, or not at all.

The administration had many reasons to quickly declare that state options were limited, but ultimately the most important one was that they didn't think it would matter. They firmly believed that state politicians might grandstand for political gain, but the allure of large amounts of federal funding (100% federal match for the first 3 years) would be far too tempting for any state to resist for long. The administration would simply need to sit tight and it would win this game of "Medicaid chicken."

As it turned out, the administration had fundamentally misread how the politics of the country had shifted in just a few years. While there was certainly a fair amount of purely political opposition to the expansion (as well as to any and all aspects of "Obamacare"), there was also a growing concern about the federal deficit and debt that outweighed the concept of "free federal dollars." Another issue that the administration underestimated was the growing sense that the traditional Medicaid program might not be the best avenue for a major coverage expansion. For many states, it was not simply a question of should you provide health coverage to low income Americans,

but a question of what types of private market approaches, or personal responsibility provisions, could be applied to a nearly 50-year-old Medicaid program to accomplish this, or in fact, were there other vehicles to accomplish that goal.

As a result of this ongoing debate, by the eve of the 2014 midterms, only slightly more than half of the states had accepted some version of the expansion. The major question that remains going forward is whether the remaining states are firmly entrenched in the "no" or "never" categories, or simply in the "not yet," or "make me a better offer" categories.

At this point it is likely that the 2014 elections will continue some of the trends that began over a year ago, when the first of the red/purple states (Arkansas) received a waiver to approach the Medicaid expansion in a unique way. In a move they called the Private Option, Arkansas expanded Medicaid in a way that, for 90% of the expansion population, looked exactly like private exchange coverage (both for their own experience, as well as for the physicians who treated them). This was an important moment as it showed not only that the Medicaid expansion did not have to be a binary decision, that the administration was willing to negotiate in order to get states to yes, but it also showed that you could sell a Medicaid expansion to a heavily conservative legislature and overcome their 75% supermajority requirement to expand coverage.

In the wake of the Arkansas approval, 3 other states—Iowa, Michigan, and Pennsylvania (at the time all with Republican governors)—also received waivers to approach the Medicaid expansion in slightly different ways. While these approaches all represented modifications to what the administration would have preferred, they did not represent fundamental threats to the administration's bedrock principle of beneficiary protections. None of those states got everything they asked for, but they all got enough to declare victory and move forward. In fact, the approval of the expansion in those states demonstrated an evolution of the administration's original thinking on the expansion, creating in effect, an iterative process where you don't know what can be approved until you ask.

The results of the midterm elections saw only 1 heavily populated state (Pennsylvania) with a Republican administration giving way to a Democratic one, and they had already decided to expand prior to the elections. On the flip side, several expansion states (Massachusetts and Maryland) saw Democratic administrations give way to Republican ones, but reversing course on the expansion in those states is practically unthinkable. What is more likely to happen, is that governors and state legislatures will feel emboldened to publicly discuss a topic that had been verboten in the lead-up to the election. Furthermore, in the wake of several states receiving waivers of the traditional method of expansion, other states will want to push the Obama administration to bend more to their way of thinking.

The most important state to watch is Indiana. Governor Pence (R) has been pushing to use the state's Healthy Indiana Program as

the platform for the Medicaid expansion. The administration has long been skeptical about taking a health savings account-type of approach for the traditional Medicaid population, but Pence appears to be resolute in his stance that it will be Healthy Indiana or nothing. While it is impossible to know for sure what the administration's strategy will be, it is clear that if Indiana gets approval for its current waiver request, it will speed up the iterative process and open many more doors and windows for other states to explore. Nevertheless, even in the event that they cannot get to "yes," states will continue to probe the administration's defenses, looking for openings and opportunities to reshape the Medicaid program as they move forward.

Federal Perspectives on Medicaid

With the GOP controlling both the House and the Senate for the next 2 years, there are likely to be numerous efforts to address not just the ACA, but entitlement programs in general. While House Speaker Boehner and (now) Senate Majority Leader McConnell have both made statements about not pushing for outright repeal of Obamacare, the internal dynamics of the Republican majority in both houses might demand more aggressive change. This could range from outright repeal efforts, or efforts to "repeal and replace," to settling for significant reforms to the law. Any legislation successfully attempting to outright repeal would be swiftly vetoed, as would most efforts to replace the ACA with something else. It is also unclear to what extent the House and Senate could agree on what the "replace" component of that would be. Efforts to make relatively minor edits (repealing the medical device tax for example) might be met with more success and not face a sure veto threat, but it is unclear if those efforts would satisfy a newly emboldened Congressional majority.

Beyond efforts to address the ACA, it is likely that Congress will reinvigorate efforts to reform entitlement programs, Medicare, Medicaid, and Social Security. Medicaid reforms of this nature would likely be some form of "block grants," more likely a version of "per capita caps." There will be competing prerogatives in this effort which will include the desire to minimize what is viewed as state "gaming" of the system, which is made possible by combining financing mechanisms such as Intergovernmental Transfers, Upper Payment Limits, and Certified Public Expenditures with the open-ended nature of Medicaid's federal funding. There will also be a drive to wrest control of Medicaid away from federal policy makers at HHS and devolve the majority of decisions down to the state government level, although that is also likely to include capping federal funding.

Any efforts to remove the entitlement nature of the Medicaid program would have to overcome threats of both Senate filibusters as well as a presidential veto. While some of those concerns could be minimized through utilization of the budget reconciliation process, they cannot be completely overcome, and the short-term prognosis

for significant Medicaid reforms remains poor.

Wild Cards

Another legal challenge to the ACA has elevated the Supreme Court to potentially make a significant impact on coverage. Early in 2015, the Court will decide whether or not federal subsidies will be invalidated in states that are not running a state health insurance exchange. While this does not directly impact Medicaid, or the other components of the ACA, this could have ripple effects in terms of states' willingness to expand the program, or even the administration's willingness to negotiate with states on novel approaches to the expansion.

An often overlooked provision of the ACA allows for a "super waiver" of many of the law's provisions, so long as the underlying goals of the law (accessible, affordable, high quality coverage) are still met. These waivers do not become effective until 2017, but some states are already thinking about using this tool to achieve long-standing health reform efforts, such as Vermont, which hopes to use the waiver authority to finally achieve single-payer coverage throughout the entire state. While there was a failed effort to move the 2017 start date for the waiver up to 2014 (an effort by Senators Wyden and Brown), soon after, the ACA's passage found very few takers for a proposal that was neither "dismantle" nor "defend at all costs."

Predictions

The number of states embracing the Medicaid expansion will continue to grow at a rate dependent on how flexible the administration is willing to be. Congress will continue to debate entitlement reform, but it is unlikely that significant changes to Medicaid will be enacted in the next 2 years. Regardless of either of these, states will continue to take the lead in reforming the program in their own ways. Transforming the delivery system into a better-coordinated, holistic approach that creates greater accountability for improved health care outcomes, and converting the payment incentives from volume to value will all have much more significant impacts on the future of the Medicaid program and the US healthcare system as a whole.

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