November 30, 2012

To: Interested Parties

From: National Health Law Program
National Women's Law Center
Center for Medicare Advocacy, Inc.
Families USA
The Leadership Conference on Civil and Human Rights
National Senior Citizens Law Center
The National Partnership for Women & Families
Disability Rights Education and Defense Fund (DREDF)
National Disability Rights Network
Judge David L. Bazelon Center for Mental Health Law

Re: Illegality of Partial Medicaid Expansion

The Affordable Care Act (ACA) expands Medicaid coverage to individuals with incomes up to roughly 133% of the federal poverty level (FPL). As explained below, we have concluded that any partial expansion (e.g. expansion to only 100% of the poverty level) is illegal and would establish a dangerous policy that the Administration should avoid.

A. *National Federation of Independent Business* does not authorize partial expansion.

In the ACA, Congress amended Title XIX of the Social Security Act to require states to provide Medicaid coverage to "all individuals" with incomes up to roughly 133% of the federal poverty level. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (section VIII). Some states are claiming that *National Federation of Independent Business v. Sebelius*, __U.S.__, 132 S.Ct. 2556 (2012) (*NFIB*) authorizes a state implementing Medicaid expansion to do less than what the statute requires. *NFIB* does no such thing.

NFIB held that Congress unconstitutionally coerced states when it enacted provisions requiring states to expand Medicaid eligibility to low income adults or risk losing all of their existing federal Medicaid funding. A majority of the Court held that the problem was "*fully remedied*" by prohibiting the Secretary from using her authority to terminate existing funding of a state that did not implement the expansion. *Id*. at 2606-07 (emphasis added). Thus, the Court explicitly found: "The Medicaid provisions of the Affordable Care Act … require States to expand their Medicaid programs by 2014 to cover *all* individuals under the age of 65 with incomes below 133% of the federal poverty line," *id*. at 2601 (emphasis in original), and

"Nothing in our opinion precludes Congress from … requiring that states accepting such funds comply with the conditions on their use." *Id.* at 2607.

Here, the conditions Congress placed on the use of the ACA funding is for states to include, in their state Medicaid plans, "all individuals" who meet the categorical description set forth in section VIII and whose income "does not exceed 133 percent of the poverty line." Nothing in the Chief Justice's *NFIB* opinion even hints at the idea that the section VIII conditions are anything other than a single coverage category, and the opinion in no way sanctions a reading of the statute to allow a state to bifurcate the expansion into subsets, for example those under 100% of poverty and those between 100-133% of poverty. Partial expansion is not authorized by *NFIB.*

B. Section VIII does not authorize partial expansion.

We also understand that some states are taking the position that the Medicaid Act allows expansion to a population group less than 133% of the poverty line. However, the statute is clear and unambiguous and does not authorize this. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) requires that "[a] State plan for medical assistance must … provide for making medical assistance available … to all individuals" who are under age 65, not pregnant, disabled or described in a previous part of (10)(A)(i), and "whose income … does not exceed 133 percent of the poverty line" applicable to the family size involved.

There can be no argument that this statute is ambiguous. Congress has clearly required "all individuals" who meet the categorical description set forth in section VIII and whose income "does not exceed 133 percent of the poverty line" to be included in the State Medicaid plan. Because of this clarity, there is no room for a federal agency to accede to a state's urging that these foundational requirements can be read otherwise. *See, e.g*., *Chevron, Inc. v. Natural Res. Def. Council, Inc*., 467 U.S. 837 (1984). *See generally Bontrager v. Ind. Fam. & Soc. Servs. Admin*., _ F.3d _, 2012 Wl 4372524 (7th Cir. Sept. 26, 2012) (finding similarly worded subsections of (10)(A) clearly and unambiguously obligate states to provide coverage such beneficiaries can privately enforce the provisions pursuant to 42 U.S.C. § 1983); *Watson v. Weeks*, 436 F.3d 1152 (9th Cir. 2006) (same) ; *Westside Mothers v. Olszewski*, 454 F.3d 532 (6th Cir. 2006) (same); *S.D. v. Hood*, 391 F.3d 581 (5th Cir. 2004) (same); *Sabree v. Richman*, 367 F.3d 180, 190 (3d Cir. 2004) (same, stating "Congress conferred specific entitlements on individuals in terms that could not be clearer.") (internal quotation and citation omitted).

C. Partial expansion is not authorized under the Social Security Act, 42 U.S.C. § 1315(a).

We also understand that some states are asking the Secretary to approve partial expansion through the authority granted to her in § 1115 of the Social Security Act (42 U.S.C. § 1315(a)). We understand the states want to have "flexibility" to provide coverage for childless adults and that some states urge the Secretary to allow them the flexibility because, under *NFIB*, the expansion is a "new" program. However, these bases simply do not satisfy the statutory requirements for a § 1115 demonstration project. Section 1115 only authorizes the Secretary to approve "experimental, pilot or demonstration projects" that are "likely to assist in promoting the objectives of the Medicaid Act." Under § 1115, the Secretary can only approve projects for the "extent and period" necessary.

In the context of partial expansion, two of the three § 1115 preconditions cannot be met. First, a partial expansion project does not offer a "pilot, demonstration or experimental" idea. *See* 42 U.S.C. § 1315. "In plain language, 'experiment' must be understood as a trial conducted for the purpose of testing a proposition." *California Welfare Rights Org. v. Richardson*, 348 F. Supp. 491, 498 (N.D. Cal. 1972). The terms "pilot" and "demonstration" have similar definitions. See Merriam-Webster Dictionary On-Line (10th Ed. 2006). According to Congress, § 1115 was intended to allow only for "experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients" that are "to be selectively approved," "designed to improve the techniques of administering assistance and related rehabilitative services," and "usually cannot be statewide in operation." S. Rep. No. 87-1589, at 19-20, as reprinted in 1962 U.S.C.C.A.N. 1943, 1961-62, 1962 WL 4692 (1962). *See also* H. R. Rep. No. 3982, pt. 2 at 307-08 (1981) ("States can apply to HHS for a waiver of existing law in order to test a unique approach to the delivery and financing of services to Medicaid beneficiaries."). The Ninth Circuit Court of Appeals put it this way,

> The statute was not enacted to enable states to save money *or to evade federal requirements* but to "test out new ideas and ways of dealing with the problems of public welfare recipients." [citation omitted] A simple benefit cut, which might save money, but has no research or experimental goal, would not satisfy this requirement. Rather, the "experimental or demonstration project" language strongly implies that the Secretary must make at least some inquiry into the merits of the experiment. She must determine that the project is likely to yield useful information or demonstrate a novel approach to program administration.

Beno v. Shalala, 30 F.3d 1057, 1069 (9th Cir. 1994) (emphasis added); *See also Cal. Welf. Rights Org*., 348 F. Supp. 491, 498 (N.D. Cal. 1972) ("As a matter of principle, it is clear that the Secretary would abuse his discretion if he were to approve a project which . . . subject[ed] an unreasonably large population to the experiment or continu[ed] it for an unreasonably long period").

Here, coverage of the population described in section VIII (non-disabled, non-elderly adults) has already been the subject of experimental projects during the 1980s and 1990s, when a number of states obtained permission under § 1115 to implement projects to provide Medicaid coverage to low income beneficiaries that included adults with incomes below the federal poverty level. The projects provided coverage to this "expansion" group using a variety of coverage features, including managed care medical homes and increased cost sharing. Data gathered by the states and others established the benefit of this coverage. *See, e.g.*, Benjamin E. Somers et al., *Mortality and Access to Care among Adults after State Medicaid Expansions*, 367 NEW ENG. J. MED. 1025 (Sept. 13, 2012) (finding Medicaid adult expansion populations in New York, Maine, and Arizona experienced significant reduction in mortality, decreased rates of delayed care, and increased self-reported health status). As part of the ACA, Congress brought this population group within the state Medicaid plan by enacting section VIII.

The ACA also amended § 1115 to provide new options for the Secretary and the states, suggesting a number of different types of experimental projects. See § 1115A. Partial expansion is not listed as an option. This makes sense: Congress now intends this group to be covered through the state plan. While there may be other unresolved questions, one thing is clear: projects that seek partial expansion (e.g. to 100% of FPL) are not experimental in nature. *Compare* CMS "Medicaid/CHIP Affordable Care Act Implementation" (May 2, 2012) (stating that currently approved § 1115 demonstrations will not continue beyond December 31, 2013, for childless adults because "States that have utilized demonstrations to expand eligibility to the childless adult population will no longer need the expenditure authority because this population will become a mandatory State plan population under the Affordable Care Act's Medicaid eligibility expansion"). Simply put, a state proposal to cover the populations group brought into the state plan through section VIII cannot, after a 20-year period of demonstration projects involving that very group, now be classified as a demonstration project.

In addition to lacking an experimental quality, partial expansion is inconsistent with § 1115 because it does not "promote the objectives of the Medicaid Act." 42 U.S.C. § 1315(a). This criterion assures that the Secretary will not exercise the discretion to ignore Congressional dictates when granting approvals. Otherwise, "administrative prerogative will quickly become legislative in nature." Mark S. Coven, *Altering State Welfare Programs Through the Administrative Waiver Process Or End-Run Around Congress,* 17 NEW. ENG. L. REV. 1175, 1192 (1982). In this specific situation, the Medicaid Act's objectives need to be assessed not just in terms of the Medicaid Act by itself, but in terms of the role the ACA meant Medicaid to play as what the Supreme Court described as "an element of a comprehensive national plan to provide universal health insurance coverage." *NFIB*, 132 S.Ct. at 2606. Here, the ACA's clearly articulated objective is to ensure that everyone with incomes below 133% of poverty, including childless adults, parents who would not have qualified for Medicaid under 42 U.S.C. § 1396u-1,

and people with disabilities whose disabilities do not meet SSI standards, will get coverage under the Medicaid Act, including cost sharing and other protections. More generally, it is the Medicaid Act's objective to ensure that everyone with incomes below 133% of poverty will have access to health insurance coverage that is affordable and includes all of the benefits specified in the Medicaid Act. A Medicaid waiver proposal that would make someone's health insurance less affordable than it would be under Medicaid, or less comprehensive than it would be under Medicaid, would be inconsistent with the objectives of the Medicaid Act as it now stands. Indeed, the common theme here is that while the ACA gives states several ways to choose how people get health insurance coverage, and gives the Secretary the responsibility to approve or disapprove state choices, it is not up to a state and/or the Secretary to decide that a person who cannot afford coverage should have no coverage at all or should have coverage that is not as good as, or is less affordable than, the Act otherwise would require.[1] This is a general principle that applies with full force to the Secretary's consideration of 1115 proposals that might reduce benefits, or make coverage less affordable, for people with incomes below 133% of FPL who qualify for coverage under section VIII.

D. Assuming arguendo that a state could implement partial expansion through § 1115, that state would not be eligible to receive enhanced federal funding.

Even if a state could develop an experimental design for a partial expansion that is consistent with the objectives of the Medicaid Act, that project would not be eligible for the enhanced Medicaid funding that is tied to Section VIII. Section 1115 only allows the Secretary to waive provisions of § 1396a. *See* 42 U.S.C. § 1315(a).

Congress established enhanced federal funding for the section VIII population not in §1396a but in §1396d, in 42 U.S.C. § 1396d(y)(1). As § 1396d is not § 1396a, it does not come within the waiver authority Congress granted to the Secretary in § 1115. Nor does § 1115 apply to the Medicaid Act's other federal financial participation provisions, 42 U.S.C. §§ 1396b(a) and 1396b(d). As stated by the Kaiser Commission, "There are some program elements the Secretary does not have authority to waive, such as the federal matching payment formula."

[1] The ACA clearly instructs the Secretary how to handle state proposals to provide services to people in ways that differ from the methods Congress laid out in the ACA. *See*, *e.g.*, 42 U.S.C. § 18051 (ACA § 1331, allowing states to offer health insurance to households between 133%-200% of FPL in lieu of coverage through Exchanges, provided that coverage is as affordable as it would be through an Exchange); § 18051(a)(2)(A) (Secretary to certify that state plan is as affordable as coverage otherwise under the ACA); § 18053 (ACA § 1333, allowing multi-state compacts, provided the coverage is as comprehensive and affordable as coverage absent such agreements); § 18053(a)(3) (Secretary may approve multi-state compacts where coverage is as comprehensive and cost sharing as affordable as coverage offered through Exchanges and to at least as many state residents as otherwise would get coverage); § 18052 (ACA §1332, as of 2017, Secretary may waive Exchange and other requirements if state will provide coverage that is at least as comprehensive and affordable as coverage would be under the Exchange).

Kaiser Comm'n on Medicaid & the Uninsured, *An Overview of Recent Section 1115 Medicaid Demonstration Waiver Authority* 3 & n.3 (May 2012) (explaining, "Specifically, Section 1115 provides authority for the Secretary to waive solely those provisions included in Section 1902 [§ 1396a] of the Medicaid Act.").

We also want to comment briefly on claims people might make about the Secretary's purported "expenditure authority." Section 1115(a)(2)(A) provides that the costs of a demonstration project which would not otherwise be included under § 1396b shall be, to the extent and for the period prescribed by the Secretary. In some previous demonstration project approvals, the Secretary has taken the position that § 1115(a)(2)(A) establishes an "expenditure authority" that allows her to provide federal Medicaid funds to states that are not complying with the requirements in the Medicaid Act. Litigation has resulted. In these cases, the Secretary repeatedly told the court that this "expenditure authority" applies to "expansion" populations that are not described in the Medicaid Act's mandatory coverage provision, 42 U.S.C. § 1396a(a)(10)(A)(i). *See Spry v. Thompson*, 487 F.3d 1272 (9th Cir.2007) (concerning non-disabled, non-elderly adults who (at the time) were not described in § 1396a(a)(10)(A)(i)); *Newton-Nations v. Betlach*, 660 F.3d 370 (9th Cir. 2011) (concerning non-disabled, non-elderly adults and medical expense deduction individuals who (at the time) were not described in § 1396a(a)(10)(A)(i)). Even assuming that rationale is correct, it clearly does not apply here. Section VIII *is* a subsection of § 1396a(a)(10)(A)(i), and this population is therefore a state plan population that is described in and covered by the Medicaid Act. And, the section VIII groups cannot be viewed as an expansion population. A previous HHS Secretary noted: "Expansion Populations: Refers to any individuals who *cannot be covered* in an eligibility group under Title XIX or Title XXI and *who can only be covered* under Medicaid or SCHIP through the §1115 [1315] waiver authority. Examples include childless non-disabled adults under Medicaid." "Health Insurance Flexibility and Accountability Demonstration Initiative" at http://www.cms.hhs.gov/hifa/hifagde.asp (emphasis added). Clearly, to allow partial expansion pursuant to § 1115 would be an unprecedented expansion of executive authority, significantly eclipsing the actions of previous Administrations.

Application of an expenditure authority here would go far beyond the limits the Secretary has previously set for the authority because it would sanction its use for a mandatory population. Section 1115 cannot be read to contain, and no court has sanctioned, such broad authority. *But compare Pharmaceutical Research and Manufacturers of America v. Thompson*, 251 F.3d 219, 222 (D.C. Cir. 2001) (rejecting Secretary's attempt to fashion authority broader than that provided by § 1115(a)(1) and finding Secretary was without authority to approve a waiver that forced drug manufacturers to pay rebates beyond those authorized by § 1396r-8—a provision that could not be waived because it is not contained in § 1396a). Such a broad, boundless authority would violate numerous legal rules of statutory construction. Simply put, if broadened to include the ability to approve partial expansion, the purposed "expenditure authority" would

render § 1115(a)(1) meaningless because the current or a future Secretary would be able to approve any expense she or he chooses, even to allow a state to ignore the beneficiary protections of the Medicaid Act completely.

E. Allowing partial expansion through § 1115 would establish a dangerous precedent.

If the current administration allows partial expansion, it will have created a dangerous slippery slope. One could see future efforts by states to cover only some currently mandatory coverage categories. This could, for example, range from § 1115 projects to cover pregnant women up to 100% of the poverty level or children up to 75% of the poverty level. Indeed, there would be little to stop future administrations from encouraging or allowing states to obtain federal Medicaid funding for programs that reflect little of the Medicaid Act that Congress has implemented. Such an interpretation would jeopardize the entire structure of the Medicaid program.

F. Allowing partial expansion would have negative policy impacts.

Some states will surely request a partial expansion to less than 100% of FPL. If a Secretary allows a state to do this, it would create a coverage gap, since 100% FPL is the minimum limit for Exchange subsidies. For example, if a state only implemented a partial expansion to 50% FPL, some individuals between 50% and 100% of FPL would be ineligible for Medicaid and ineligible for Exchange subsidies. This would subvert the promise of health reform and lead to many practical problems associated with uninsured populations, such as high use of emergency rooms and "churning."

Even if a state implemented a partial expansion up to 100% FPL, it would still result in many uninsured individuals because coverage premiums would be unaffordable for many individuals who otherwise would have been assured coverage through the Medicaid Expansion. Even if these individuals in the 100-133% FPL group were able to obtain coverage, numerous serious problems are inevitable:

- Medicaid offers a tailored benefits package designed to meet the needs of low income people. The most vulnerable individuals in this population will be exempted from Medicaid benchmark coverage, and will receive a full state plan benefit specifically designed for low income individuals. Exchanges, in contrast, will offer a private plan benefits package that is not tailored to their needs. Even the individuals in the Medicaid Expansion who are not exempted are guaranteed to have the same or better coverage than in the Exchange. The Exchange Essential Health Benefits standard forms the *floor* for the Medicaid Expansion, and the Medicaid benchmarks also have other independent requirements to include family planning and achieve mental health parity.

- Cost-sharing in the Exchanges was not designed for individuals below 133%. Many individuals will be unable to actually use their insurance because of an inability to pay cost-sharing. This has dire consequences when it occurs.
- The cost of covering the 100-133% population through the Exchange would be much more expensive for the Federal government. Instead of (eventually) paying 90% of a lesser Medicaid cost, the Federal government would pay 100% of the greater Exchange subsidy cost. Put simply, instead of paying 90% of the cheapest health care costs that exist, the Federal government would pay 100% of the most expensive rates. If multiplied over the full Medicaid Expansion population above 100%, this would be a tremendous and wasteful cost.
- Shifting the 100-133% group from Medicaid to the Exchange would worsen the risk pool profile for the Exchange, driving up the cost of Exchange coverage and exacerbating "affordability" concerns.
- Implicating partial expansion is a state "flexibility" effort, could undermine health access and health reform. For example, a state may negotiate for a package of partial Medicaid expansion plus managed care to enroll individuals other than the expansion group into managed care with reduced benefits and federal financial support for enrollment in a state-operated Exchange. Allowing partial expansion would make it hard to draw a rational line, and if one state negotiates a package like this, other states may want to follow. (We understand the 1331 basic health program and the 1332 state innovation waiver are both supposed to have a no-reduced-benefits rule, but 1331 applies to the 133%-200% population and 1332 innovation waivers do not start for several years.)
- Allowing a partial Medicaid expansion will increase costs for some businesses, particularly employers with a low-wage workforce who would face greater liability for coverage penalties. The statute requires larger employers – those with 50 or more full-time employees – that do not offer coverage themselves to pay a per-worker penalty of $2,000 if at least one full-time employee receives a premium tax credit. This fee does not apply to the first 30 workers in their workforce. Employers that do not offer coverage must pay the lesser of $3,000 for each employee that actually receives a premium tax credit, or $2,000 for each full-time employee, again excluding the first 30 workers. Employers with predominantly low-wage workforces are less likely to offer health insurance coverage and, if they do, more likely to have employees decline to enroll. If workers with incomes between 100 and 133 percent of poverty are eligible for tax credits but not Medicaid coverage, these employers face a greater likelihood of paying this assessment, or paying a higher total penalty.

Overall, a partial Medicaid expansion would cost more for the federal government (due to increased tax credit expenditures), individuals, and employers. Allowing partial expansions would also undermine on-going ACA implementation effort. Countless health care stakeholders who support the ACA across the country have spent months working to promote implementation

of section VIII, as it is written. Subsequent to the elections, many state legislatures have become more supportive of ACA implementation and even some generally unsupportive state leaders have signaled a willingness to move forward with it. Allowing partial expansions would set back this progress and erode the confidence stakeholders and the public are now gaining on the important promise that the ACA holds for the future of the health care system and health coverage for most Americans. It would also open the door to a reduced commitment by *all* states. For every state that commits to a partial expansion there will be others who drop support for full expansion. For example, California was fully committed to Medicaid Expansion but now has been reconsidering its options until the federal government determines whether a partial expansion will be allowed.

Conclusion

For the above reasons, we strongly oppose any consideration by the Secretary to allow states to implement partial Medicaid Expansions or receive enhanced matching funds for covering only a part of the section VIII population. We instead urge CMS to adopt a clear policy on this point to avoid legal complications and to preserve the integrity of the Medicaid program as Congress enacted it. Please do not hesitate to contact Jane Perkins, perkins@healthlaw.org, or Leonardo Cuello, cuello@healthlaw.org, if you have any questions or would like to discuss the matter further.