

MEDICAID EXPANSION
 BY ANY OTHER NAME:
 EXPLORING THE FEASIBILITY
 OF EXPANDED ACCESS TO CARE IN
 THE WAKE OF *NFIB v. SEBELIUS*

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INTRODUCTION

Over 160,000 individuals in Tennessee are living in or near poverty and are uninsured because they do not qualify for Medicaid and cannot afford to buy insurance on their own.¹ These individuals bear witness to a broken Medicaid program that is an artifact of historical judgments about the “deserving poor.”² Medicaid has traditionally provided health care coverage only to certain categories of individuals living in poverty. Attempting to right this wrong, The Patient Protection and Affordable Care Act (the “Affordable Care Act” or “ACA”) expanded Medicaid eligibility to essentially all individuals who fall at or below 133 percent of the federal poverty line. However, the Supreme Court’s decision in *National Federation of Independent Business v. Sebelius (NFIB v. Sebelius)*³ unwound this federal remedy by making the Medicaid expansion optional for the states.

In the wake of this decision, two options have emerged for states seeking to provide health care to the poor and uninsured, and more—specifically individuals at or below 133 percent of the federal poverty line. The first option is for a state to accept the Medicaid expansion in accordance with the terms of the ACA. With this choice, a state would receive full federal funding for the program for the first three years, and no less than ninety percent funding after that point. The second option is for a state to apply for a waiver from the federal government to use federal Medicaid funds for premium subsidies that would enable the Medicaid expansion population to buy commercial insurance. Both options demonstrate an exemplar of cooperative governance—enabling the shared

1. *The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid*, THE HENRY J. KAISER FAMILY FOUND., 5 (Oct. 23, 2013), <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

2. Nicole Huberfeld, Elizabeth Weeks Leonard & Kevin Outterson, *Plunging into Endless Difficulties: Medicaid and Coercion in National Federation of Independent Business v. Sebelius*, 93 B.U. L. REV. 1, 13 (2013), available at <http://www.bu.edu/law/central/jd/organizations/journals/bulr/volume92n4/documents/OUTTERSON.pdf>.

3. 132 S. Ct. 2566 (2012).

goal of providing health care coverage for those in need to be achieved through federal funding and state flexibility. However, the waiver programs are subject to important limitations, namely, a waiver program must still promote the central goals of Medicaid.

On March 27, 2013, in an address to the Tennessee General Assembly, Governor Bill Haslam announced a proposed plan (the “Tennessee Plan”) to pursue the second option for addressing the existing gap in Medicaid coverage.⁴ In lieu of expanding Medicaid eligibility through the route envisioned by the ACA, Governor Haslam proposed the Tennessee Plan, which would employ a federal waiver to direct federal Medicaid funds toward providing premium subsidies for low income Tennesseans. These premium subsidies would enable individuals in the Medicaid expansion population to purchase private coverage on the newly created health insurance marketplace.⁵

This Article will examine these aspects of the Tennessee Plan in order to make the argument that Tennessee must either accept the Medicaid expansion as codified in the Affordable Care Act, or make modifications to the Tennessee Plan that better comport with the federal waiver program, the central goals of Medicaid, the United States Constitution, and the spirit of cooperative federalism.

PART I. *NFIB v. SEBELIUS*: THE IMPACT OF THE SUPREME COURT’S DECISION

To put the Supreme Court’s decision in *NFIB v. Sebelius* into context, Part I of this Article contains two sections. Section A provides a brief background of the Medicaid program and the changes that the ACA, in its original form, attempted to incorporate. Section B analyzes the Supreme Court’s reasoning and the impact of the decision.

A. Background of Medicaid before the ACA

The Social Security Act of 1965 introduced the federal health care programs Medicare and Medicaid.⁶ In general, Medicare is a social insurance program with benefits available to disabled individuals and the elderly without regard to their means. Medicaid, on the other hand, has developed into a type of welfare program for eligible recipients who meet a threshold economic need and are within a category of people deemed to be worthy of receiving aid. When originally passed by Congress, Medicaid covered specific populations that fell within conventional notions of the

4. Haslam Unveils ‘Tennessee Plan’ for Health Care Reform, TN.GOV (Mar. 27, 2013, 9:51 AM), <https://news.tn.gov/node/10458>.

5. *Id.*

6. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended at 42 U.S.C. § 1315(a)(1)).

“deserving poor,”⁷ including the aged, blind, and permanently and totally disabled. The program also covered dependent children and their relative caretakers below specified poverty levels.⁸ By the 1980s, Medicaid was expanded to cover additional low-income children and pregnant women.⁹ These rigid categories left many low-income individuals without access to Medicaid, most notably low-income, non-disabled, single adults.

Though states can choose to cover additional populations, federal matching dollars are only available for the mandatory eligibility categories established by Congress. This dichotomy of state programmatic flexibility and federal financial constraint is an artifact of the very structure of Medicaid. The Medicaid program is an example of cooperative federalism, wherein the federal government provides a significant portion of federal funds for a specified program that is then implemented by the states.¹⁰ Every state administers its own Medicaid program with joint funding from the federal government.¹¹ Cooperative federalism is reflective of three attributes of the United States’ republican form of government: (1) state and federal governments share some common goals, including the goal of “promot[ing] the general welfare” of citizens;¹² (2) the “power to lay and collect taxes”¹³ affords the federal government greater ability to finance programs that will realize shared goals; and (3) there are differences among the states that warrant some independence and flexibility in implementing these programs.¹⁴

Seeking to provide coverage for all individuals living in poverty, the ACA established an income-based category that would have been mandatory in all states. Instead of eligibility dependent on both economic and categorical need, eligibility would be determined on means alone.¹⁵ As drafted, the ACA required all states to expand their Medicaid programs to include this population, and states were offered 100 percent funding initially and dropping to 90 percent by 2020 to expand the Medicaid population. To the extent the state did not accept the funding to expand the Medicaid population, the Secretary for the Department of Health and Human Services (“HHS”) had the discretion to withdraw all federal Medicaid funds from a state, including funding for non-expansion, pre-

7. Huberfeld et al., *supra* note 2, at 13.

8. Schweiker v. Gray Panthers, 453 U.S. 34, 37 (1981).

9. Huberfeld et al., *supra* note 2, at 23.

10. *See, e.g.*, Wis. Dep’t of Health & Family Servs. v. Blumer, 534 U.S. 473, 495 (2002) (stating that Medicaid “is designed to advance cooperative federalism”).

11. Huberfeld et al., *supra* note 2, at 17–18.

12. U.S. Const. pmbl; *see, e.g.*, Tenn. Const. art. I, § 2 (stating that government is “instituted for the common benefit”).

13. U.S. CONST. art. I, § 8, cl. 1.

14. *See* Philip J. Weiser, *Towards a Constitutional Architecture for Cooperative Federalism*, 79 N.C. L. Rev. 663, 669 (2001) (explaining that cooperative federalism provides states significant discretion in administering policies).

15. *NFIB v. Sebelius*, 132 S. Ct. at 2582.

ACA Medicaid populations. States opposing the Medicaid expansion, as well as other provisions of the ACA, brought suit, leading to the Supreme Court's grant of certiorari in *NFIB v. Sebelius*.¹⁶

B. Supreme Court Passing the Choice of Expansion to the States

On the last day of the 2012 term, the Supreme Court finally issued its ruling in one of the most watched cases of the year, *NFIB v. Sebelius*.¹⁷ Earlier that spring, the Court heard a nearly unprecedented six hours of oral argument¹⁸ related to four legal challenges raised against the health care law: the applicability of the Anti-Injunction Act; the constitutionality of the individual mandate; the severability of the Affordable Care Act should the individual mandate be struck down; and whether the Medicaid expansion was unduly coercive.¹⁹ Most everyone watching this case, including legal scholars, assumed that the individual mandate was the Achilles heel of the Affordable Care Act.²⁰ Thus, the Court's June 28, 2012 decision caught many by surprise.

In a plurality opinion authored by Chief Justice John Roberts, the Court held that while the individual mandate was a permissible use of Congress' taxing power,²¹ the Medicaid expansion was an unconstitutionally coercive exercise of the Spending Clause.²² In its brief, the National Federation of Independent Businesses—joined by a coalition of twenty-six states²³—argued that the mandatory expansion of Medicaid to individuals living at or below 133 percent of the federal poverty line, when combined with the ability of the federal government to withhold existing Medicaid funding should a state fail to expand Medicaid eligibility, violated the anti-compulsion principles of the Spending Clause.²⁴ And, for the first time in the history of American jurisprudence, a majority of the Supreme

16. See generally Huberfeld et al., *supra* note 2, at 29–34 (providing information of the procedural posture regarding *NFIB v. Sebelius*).

17. *Id.*

18. Andrew Christy, 'Obamacare' Will Rank Among the Longest Supreme Court Arguments Ever, NAT'L PUB. RADIO (Nov. 15, 2011, 5:11 PM), <http://www.npr.org/blogs/itsallpolitics/2011/11/15/142363047/obamacare-will-rank-among-the-longest-supreme-court-arguments-ever>.

19. *NFIB v. Sebelius*, 132 S. Ct. 2566, 2581 (2012).

20. Huberfeld et al., *supra* note 2, at 3–4.

21. *NFIB*, 132 S. Ct. at 2601 (Ginsburg, J., Sotomayor, J., Kagan J., and Breyer, J. concurring).

22. *Id.* at 2606–07.

23. Florida *ex rel.* Bondi v. U.S. Dep't of Health and Human Servs., 780 F. Supp. 2d 1256, 1263 n.1 (N.D. Fla. 2011) ("The states are Alabama, Alaska, Arizona, Colorado, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin, and Wyoming.").

24. *NFIB*, 132 S. Ct. at 2582.

Court agreed.²⁵ Importantly, the Court did not strike down the expansion itself,²⁶ though four justices would have.²⁷ Instead, the Court prohibited the federal government from placing existing Medicaid federal funding in jeopardy should a state choose not to expand Medicaid.²⁸ The practical effect of this ruling was to make the Medicaid expansion optional for the states.

Several aspects of this opinion are troubling, in particular, the way that the Court contorted the practical realities of those living in poverty, as well as the law, in order to reach the decision it did on the Medicaid expansion.²⁹ The Court's determination that the Medicaid expansion was unduly coercive relied, in part, on a finding that the Medicaid expansion represented a new Medicaid program.³⁰ In the words of Chief Justice Roberts:

The Medicaid expansion, however, accomplishes a shift in kind, not merely degree. The original program was designed to cover medical services for four particular categories of needy: the disabled, the blind, the elderly, and needy families with dependent children. . . . Under the Affordable Care Act, Medicaid is transformed into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level. It is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health care coverage.³¹

As Chief Justice Roberts notes, until the passage of the Affordable Care Act, the Medicaid program only recognized certain categories of eligibility.³² These categories are artifacts of the Elizabethan poor laws, and serve as codified evidence of society's normative determinations about the "deserving" and "undeserving" poor.³³ In stating that those living under 133 percent of the federal poverty line do not qualify as "the neediest among us,"³⁴ Chief Justice Roberts contributes to this regrettable history rather than unwinding it, ignoring the realities of millions of Americans living in

25. *Id.* at 2566, 2606–07, 2666 (Scalia, J., Kennedy, J., Thomas, J., and Alito, J., dissenting).

26. *Id.* at 2607.

27. *Id.* at 2666 (Scalia, J., Kennedy, J., Thomas, J., and Alito, J., dissenting).

28. *Id.* at 2607.

29. *See id.* at 2605–06.

30. *See id.*

31. *Id.*

32. *Id.*

33. Huberfeld et al., *supra* note 2, at 13.

34. *NFIB*, 132 S. Ct. at 2605–06 (joined by Breyer J., and Kagan, J.).

poverty. As Justice Ginsburg noted in her dissent, “Single adults earning no more than \$14,856 per year—133 percent of the current poverty level—surely rank among the Nation’s poor.”³⁵

Some of the legal analysis in *NFIB v. Sebelius* is also troubling. The two legal questions at issue with respect to the Medicaid expansion were: (1) whether congressional action taken pursuant to the Spending Clause is subject to legally enforceable limits pursuant to the Tenth Amendment; and (2) whether Congress exceeded those limits in passing the Medicaid expansion.³⁶ In his discussion, Chief Justice Roberts deftly intermingles case law addressing the limits of the Commerce Clause with that of the Spending Clause.³⁷ In just a few paragraphs, two previously distinct areas of the law were seamlessly married. This union enabled the Court to create, for the first time ever, a limit on Congress’ authority to regulate states under the Spending Clause.³⁸ However, in uniting these two areas of law, the Court gives little mind to the fundamental difference between the Commerce Clause and the Spending Clause. The Commerce Clause cases that the Court cited in the opinion essentially ask the question, “To what extent can the federal government regulate the independent, non-federally funded actions of the states?”³⁹ In contrast, the cited case law in Spending Clause litigation asks the question, “When the federal government provides funding for a state program, what are the limits on the federal government’s ability to regulate that state program?”⁴⁰ It seems intuitive that greater deference should be afforded to federal regulation when the government is regulating a program receiving federal funds.⁴¹ However, in conflating these two areas of law, the opinion virtually ignores this common sense understanding.⁴²

Chief Justice Roberts does, however, note that this limitation only applies to actions under the Spending Clause that create a situation where the “[s]tate has no choice.”⁴³ According to Chief Justice Roberts, the

35. *Id.* at 2636 (Ginsburg, J., dissenting).

36. *Id.* at 2602–04.

37. For example, a paragraph that begins with the statement, “At the same time, our cases have recognized limits on Congress’s power under the Spending Clause,” contains citations to both Spending Clause and Commerce Clause case law. *Id.* at 2602 (citing *Barnes v. Gorman*, 536 U.S. 181, 186 (2002) (discussing Congress’ power under the Spending Clause), *Penhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981) (discussing Congress’ power under the Spending Clause), and *New York v. United States*, 505 U.S. 144, 156–60 (1992) (discussing Congress’ power under the Commerce Clause)).

38. *Id.* at 2630.

39. *See, e.g., New York*, 505 U.S. at 156–60.

40. *See, e.g., Barnes*, 536 U.S. at 186; *Penhurst State Sch. & Hosp.*, 451 U.S. at 17.

41. Erwin Chemerinsky, *Protecting the Spending Power*, 4 *CHAP. L. REV.* 89, 101 (1989) (“In other words, the spending power is different from the commerce power relative to the Tenth Amendment. . . . Even the seminal case creating the anti-commandeering principle recognizes this distinction.”) (citing *New York*, 505 U.S. at 144).

42. *See NFIB*, 132 S. Ct. at 2602.

43. *Id.* at 2603.

Medicaid expansion falls into this “no choice” category because the Medicaid program is so large and expensive and states have “developed intricate statutory and administrative regimes over the course of many decades to implement . . . Medicaid.”⁴⁴ In other words, the actions of Congress should be limited because the federal government has been too generous and the states have become too reliant on this program. As Justice Ginsberg asked, “[I]s it not passing strange to suggest that the purported incursion on state sovereignty might have been averted, or at least mitigated, had Congress offered the [s]tates *less* money to carry out the same obligations?”⁴⁵ Indeed, the Roberts opinion turns the logic of cooperative federalism on its head.

Chief Justice Roberts’ opinion discounts the very core of the Medicaid system—cooperative federalism. Essentially, cooperative federal programs exist because there are solutions to societal problems that states cannot afford to address *and* there are particularized state issues that cannot be fully accommodated by one-size-fits-all federal programs. Chief Justice Roberts’s opinion renders the federal strength the enemy of state flexibility, instead of recognizing that they are both necessary components of successful cooperative governance. Regardless, the impact of the Court’s opinion is clear: the baton has been passed to the states.

PART II. PROVIDING HEALTH CARE TO THE POOR AND UNINSURED: STATE OPTIONS REGARDING MEDICAID EXPANSION

After the Supreme Court’s decision in *NFIB v. Sebelius*, states wishing to provide Medicaid coverage to ACA’s now statutorily defined Medicaid population have two choices: (1) expand Medicaid in accordance with the ACA or (2) apply for a 1115 waiver to administer a state plan. Tennessee is opting for the second option. Part II of this Article contains two sections to put Tennessee’s decision into context. Section A details the 1115 waiver option, specifically the limitations associated with these state plan alternatives. Section B breaks down the status of the state decisions regarding expansion at the time of this Article’s publication, including the states choosing traditional expansion or an alternative state plan under 1115, as well as the states choosing to not expand their Medicaid programs.

A. Medicaid Law Governing State Plan Alternatives

As noted above, Medicaid is an example of cooperative federalism.⁴⁶ With respect to Medicaid, a state is allowed some flexibility in shaping its program by choosing from various federally authorized options

44. *Id.* at 2604.

45. *Id.* at 2636 (Ginsburg, J., dissenting in part and concurring in part).

46. *See* Wis. Dept. of Health and Family Servs. v. Blumer, 534 U.S. 473, 495 (2002) (stating that Medicaid “is designed to advance cooperative federalism.”).

which policies to include in a state plan;⁴⁷ however, the federal government has established certain minimum benefits and protections that must be provided should a state accept federal Medicaid funds.⁴⁸ Section 1115 of the Social Security Act⁴⁹ provides a significant exception: States may apply to receive waivers of specific federal Medicaid standards in order to implement an “experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of” the Social Security Act.⁵⁰

The statutory authority to conduct experimental demonstration projects was added to the Social Security Act in 1962,⁵¹ and when the Social Security Act was amended in 1965 to create the Medicaid program, this waiver authority extended to this new federal health program.⁵² Pursuant to this authority, the Secretary is allowed to waive the requirements spelled out in the United States Code.⁵³ Thus, these 1115 waivers enable states, subject to the approval of the Secretary, to implement broad changes to the structure of the Medicaid program. For example, in 1993, Tennessee received approval for a demonstration project that transformed Tennessee’s Medicaid program from a traditional fee-for-service program into Medicaid managed care.⁵⁴ The 1115 waiver is also the mechanism through which Tennessee can pursue an alternative to the Medicaid expansion.

Despite affording the states a great deal of flexibility, there are several important limitations that govern the approval, review, and renewal of 1115 waivers. Specifically, when reviewing a waiver proposal, the Secretary must consider three important features of the proposed program. First, the Secretary must consider whether the proposed project is truly experimental.⁵⁵ When Congress created this waiver authority, it specified that the purpose of the authority is to “test out new ideas and ways of dealing with the problems of public welfare recipients.”⁵⁶ At the time of enactment, Congress specified that the waivers were “expected to be

47. 42 U.S.C. § 1396(a) (2011).

48. *Alexander v. Choate*, 469 U.S. 287, 289 (1985).

49. 42 U.S.C. § 1315 (2011).

50. *Id.*

51. Wilbur J. Cohen & Robert M. Ball, *Public Welfare Amendments of 1962 and Proposals for Health Insurance for the Aged*, 25 SOC. SEC. BULL. 3, 3 (1962), available at <http://www.ssa.gov/policy/docs/ssb/v25n10/v25n10p3.pdf>.

52. Social Security Amendments of 1965.

53. 42 U.S.C. § 1396(a).

54. See *TennCare Overview*, <http://www.tn.gov/tenncare/news-about.shtml> (last visited Dec. 20, 2013); *TennCare Timeline*, <http://www.tn.gov/tenncare/news-timeline.shtml> (last visited Dec. 20, 2013).

55. 42 U.S.C. § 1315(a); see also *Newton-Nations v. Betlach*, 660 F.3d 370, 380 (9th Cir. 2011); *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994).

56. S. Res. 1589, 87th Cong. (1962) (enacted); see also H.R. Res. 1414, 87th Cong. (1962) (enacted).

selectively approved by the Department.”⁵⁷ Read in concert, these statements of congressional intent demonstrate that 1115 waivers were intended to be a unique mechanism for *testing* unique programs. The import of this limitation—that Section 1115 waivers must be used to test a novel, experimental program—has also been recognized by the courts.⁵⁸ For example, in a case finding that the Secretary had exceeded the scope of her approval authority, the Ninth Circuit noted that “[a] simple benefits cut, which might save money, but has *no research or experimental goal*, would not satisfy this requirement.”⁵⁹

Second, the Secretary must make a determination that the proposed project is “likely to assist in promoting the objectives of [the Medicaid] Act.”⁶⁰ In other words, the projected outcomes of an experimental program must serve the central goals of Medicaid. The goals of Medicaid are clearly stated in the Social Security Act.⁶¹ The Medicaid program was designed

”to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care”⁶²

With the passage of the Affordable Care Act, this list was expanded to include single, childless adults living at or below 133 percent of the federal poverty line.⁶³

Third, the Secretary must make a determination regarding the “extent and . . . period” necessary for the project.⁶⁴ This language reflects the congressional intent that these waivers should be not just limited in frequency (thus the requirement that programs be unique), but also limited in scope and duration.⁶⁵ Though these requirements have since been relaxed, past demonstration waivers were typically approved for a short

57. S. Res. 1589, 87th Cong. (1962) (enacted).

58. *Beno*, 30 F.3d at 1069.

59. *Id.* (emphasis added).

60. 42 U.S.C. § 1315(a); see *Grier v. Goetz*, 402 F. Supp. 2d 876, 881 (M.D. Tenn. 2005) (noting that TennCare is a “special demonstration project authorized by the . . . Secretary . . . pursuant to the waiver authority conferred by section 1115 of the Social Security Act.”); see also *Newton-Nations*, 660 F.3d at 374; *Beno*, 30 F.3d at 1061.

61. 42 U.S.C. § 1396–1 (2011).

62. *Id.*

63. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

64. 42 U.S.C. § 1315(a); see also *Newton-Nations*, 660 F.3d at 380; *Beno*, 30 F.3d at 1061–71.

65. See 42 U.S.C. § 1315(a).

(three to five year), non-renewable term, and often were not statewide in scope.⁶⁶

Additionally, when a state has proposed a waiver from cost-sharing requirements, the Secretary must evaluate the proposed plan under Section 1396o(f), an even more rigorous waiver evaluation standard.⁶⁷ Cost-sharing can be broadly defined as payments that must be made before medical services can be obtained.⁶⁸ Examples of cost-sharing include copayments, coinsurance, and deductibles.⁶⁹ The Social Security Act sets strict limits on cost-sharing,⁷⁰ but states may apply for waivers from these requirements.⁷¹ In contrast to the broader language of Section 1115 of the Social Security Act, Section 1396o(f) details a highly circumscribed waiver authority for cost sharing requirements.⁷² Pursuant to Section 1396o(f), cost sharing programs proposed under Section 1115 must: (1) be approved by the Secretary; (2) last no longer than two years; (3) test a unique and “previously untested” use of cost-sharing; (4) provide benefits that are not outweighed by risks to beneficiaries; (5) be based on a reasonable hypothesis that will be tested in a “methodologically sound manner”; and (6) be voluntary or contain provisions to address any damage to beneficiary health as a result of mandatory participation.⁷³

B. Current Status of State Decisions Regarding the Medicaid Expansion

At the time of this publication, twenty-five states and the District of Columbia are moving forward with the Medicaid expansion, nineteen are not moving forward, and the debate is considered ongoing in six states, including Tennessee.⁷⁴ However, this breakdown is subject to additional nuance. Three of the states that have been categorized as “moving forward with an expansion” (Arkansas, Iowa, and Michigan) have pursued an alternative means of expanding access to health care coverage.⁷⁵ Additionally, in three states where the debate is considered ongoing

66. Jane Perkins, *Fact Sheet: Federal Authority to Approve Medicaid Demonstration Projects*, NAT'L HEALTH LAW PROGRAM (July 2005), <http://www.oregonadvocates.org/geo/search/download.68462> (citing Memorandum from David Ellwood, Bruce Vladeck, and Laurence Love, U.S. Dep't of Health and Human Servs., to U.S. Dep't of Health and Human Servs. Sec'y (June 22, 1993)).

67. 42 U.S.C. § 1396o(f) (2006).

68. *See* 42 U.S.C. § 1396o-1(a)(3) (2006).

69. *See id.*

70. *See, e.g.*, 42 U.S.C. § 1396o(a); 42 C.F.R. §§ 447.51–.53 (2014).

71. 42 U.S.C. § 1396o(f).

72. *See id.*

73. *Id.*

74. *Status of State Action on the Medicaid Expansion Decision, 2014*, THE HENRY J. KAISER FAMILY FOUND., <http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medic-aid-under-the-affordable-care-act/#map> (last visited Feb. 25, 2014).

75. *Id.*

(Indiana, Pennsylvania, and Tennessee), an alternative means of expansion is considered the most likely route to expanded coverage.⁷⁶ It is this category—the alternative means of expanding coverage—that occupies the central focus of this Article. Arkansas,⁷⁷ Iowa,⁷⁸ and Michigan⁷⁹ have all submitted formal proposals to the Centers for Medicare and Medicaid Services (“CMS”) for a demonstration project that creates some form of a commercial insurance alternative, and these proposals were approved.⁸⁰ Indiana⁸¹ and Pennsylvania⁸² have submitted proposals, but they have not yet been approved by CMS.⁸³ Tennessee, however, has not yet submitted a formal proposal, but Governor Haslam has indicated to HHS Secretary Kathleen Sebelius that the State would like to explore a commercial insurance alternative, the Tennessee Plan.⁸⁴ The details of the Tennessee Plan—as sparse as they are—as well as the mechanism through which the State will seek approval for this demonstration project, are explained at greater length below.

PART III. THE TENNESSEE PLAN: AN ALTERNATIVE TO THE MEDICAID EXPANSION

Central to the goal of the traditional Medicaid expansion is covering those currently poor and uninsured individuals at or below 133 percent of the federal poverty line. While alternative state programs must have this same end goal of providing health care to the expansion population, the outcome of alternative, experimental programs will not

76. *Id.*

77. *Arkansas Health Care Independence Program (Private Option)*, CENTERS FOR MEDICARE AND MEDICAID SERVS. (Sept. 27, 2013), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf>; *see also Arkansas 1115 Waiver Application*, ARK. DEP’T OF HUMAN SERVS., DIV. OF MED. SERVS., <https://www.medicaid.state.ar.us/Download/general/comment/FinalHCIWApp.pdf> (last visited Feb. 25, 2014).

78. *Iowa Marketplace Choice Plan Section 1115 Demonstration*, CENTERS FOR MEDICARE AND MEDICAID SERVS. (Dec. 30, 2013), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-ca.pdf>; *see also Marketplace Choice Plan 1115 Waiver Application*, IOWA DEP’T OF HUMAN SERVS. (Aug. 2013), *available at* http://www.dhs.state.ia.us/uploads/IAMktplaceChoice1115_Final.pdf.

79. *Healthy Michigan Plan*, MICH. DEP’T OF CMTY. HEALTH, http://www.michigan.gov/mdch/0,4612,7-132-2941_4868_4897-299404--,00.html (last visited Feb. 25, 2014).

80. *Status of State Action on the Medicaid Expansion Decision, 2014*, *supra* note 74.

81. *Healthy Indiana Plan 1115 Waiver Extension Application*, IND. FAMILY AND SOC. SERV. ADMIN. (Apr. 12, 2013), <http://www.in.gov/aca/files/April122013HIPWaiverExtensionApp.pdf>.

82. *Draft Healthy Pennsylvania 1115 Demonstration Application*, PA. DEP’T OF PUB. WELFARE, (Dec. 2013), http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/p_039654.pdf.

83. *Status of State Action on the Medicaid Expansion Decision, 2014*, *supra* note 74.

84. Letter from Governor Bill Haslam to Secretary Kathleen Sebelius (Apr. 1, 2013) [hereinafter Haslam Letter, Apr. 2013] (on file with author).

necessarily be the same as traditional programs because the means of an alternative program differ from traditional expansion. The Tennessee Plan in its current form may prove to be an example of this problem—potentially causing harm to the State’s expansion population. Furthermore, regardless of the potential effect of the Tennessee Plan, the State’s requests appear too far afield from the central goals of Medicaid such that the Secretary would deny certain portions or the entirety of the Tennessee Plan. Either partial or full denial could prevent an enactment of an alternative program in Tennessee; thus, the expansion population would be denied proper benefits. For example, even if the Secretary strikes only certain provisions, the State would be left with a plan that is considerably less flexible. The new program may be too inflexible for the State to have sufficient support to implement an alternative plan.

To analyze these problems, Part III contains four sections. Section A provides an overview of the Tennessee Plan in its current form. Section B addresses the sunset clause and payment reform in the Tennessee Plan. Next, Section C analyzes the potential issues with certain Medicaid benefits for the expansion population and provides recommendations for two Medicaid benefits: early and periodic screening, diagnosis, and treatment, known as “EPSDT”; and non-emergency transportation. Finally, Section D identifies two Medicaid protections in the Tennessee Plan—cost-sharing and due process—that might be insufficient for the Secretary to approve of their implementation.

A. Overview

In Tennessee, there are at least 161,500 individuals who would be eligible for Medicaid if the State adopted coverage for the expansion population.⁸⁵ This sizable group of uninsured individuals includes thousands of childless men and women, veterans, African-Americans, and parents who can no longer claim their children as dependents, but are not old enough to qualify for Medicare. Furthermore, approximately half of Tennessee’s expansion population is among the working poor.⁸⁶ In other words, categorical eligibility has created large gaps in coverage, excluding many Americans who are living in poverty, and these gaps are evident in Tennessee. Despite Chief Justice Roberts’ assertions to the contrary, for the hundreds of thousands of Tennesseans who are made more vulnerable by poverty and lack of access to health insurance, the Medicaid expansion would have touched those in our state who are “the neediest among us.”

On March 27, 2013, in an address to the Tennessee General Assembly, Governor Bill Haslam announced that that in lieu of expanding Medicaid eligibility as envisioned by the ACA, Tennessee would seek a waiver to use federal Medicaid funds to provide premium subsidies to low

85. *The Coverage Gap*, *supra* note 1.

86. *Id.*

income Tennesseans, enabling them to purchase private coverage on the newly created health insurance marketplaces.⁸⁷ In a letter to Secretary Sebelius dated April 1, 2013, Governor Haslam briefly outlined his proposed Tennessee Plan.⁸⁸ Specifically, he requested the following concessions from the federal government: (1) the ability to use Medicaid expansion funding to purchase private plans for the expansion population on the health insurance marketplace; (2) permission to treat the Medicaid expansion population in the same manner as all others in the marketplace; (3) waiver of Medicaid cost-sharing rules, which would enable the state to impose cost sharing requirements on the expansion population that would be the same as those levied against individuals in the marketplace who are at 250 percent of the federal poverty line; (4) inclusion of a “circuit breaker” or sunset clause that would automatically end the program when federal funding declines; and (5) permission to implement provider payment reforms.⁸⁹

Essentially, the Tennessee Plan proposes using the federal Medicaid expansion funds to provide premium assistance to individuals in Tennessee who are currently not eligible for TennCare (the Tennessee Medicaid program) and who are living at or below 133 percent of the federal poverty line.⁹⁰ If Tennessee had opted simply to expand Medicaid, all individuals under 133 percent of the federal poverty line who are currently not eligible for Medicaid would be able to get coverage through TennCare.⁹¹ For this “expansion population” the federal funding (also known as the federal match rate) would have been 100 percent for the first three years.⁹² Under the proposed Tennessee Plan, the federal funds that would have been used to provide a 100 percent match would now be distributed to individuals in the expansion population through premium subsidies.⁹³ These individuals would use this premium assistance, which would cover the full cost of an annual insurance payment, to enroll in private insurance plans in the health insurance marketplace.⁹⁴ Basically, these premiums would operate as health insurance vouchers for individuals in the expansion population.

87. *Haslam Unveils ‘Tennessee Plan’ for Health Care Reform*, TN.GOV (Mar. 27, 2013, 9:51 AM), <https://news.tn.gov/node/10458>.

88. Haslam Letter, Apr. 2013, *supra* note 84.

89. *Id.*

90. *Id.*

91. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

92. As a means of comparison, Tennessee’s match rate for individuals who are currently enrolled in Medicaid is roughly 66%, which means that for every two dollars that the government contributes to Tennessee for its Medicaid program, Tennessee must match this funding with a dollar of its own. *Status of State Action on the Medicaid Expansion Decision, 2014*, *supra* note 74.

93. Haslam Letter, Apr. 2013, *supra* note 84.

94. *Id.*

At a broad, conceptual level, this alternative approach is fairly unobjectionable as federal funds will be used to provide coverage to those who are currently uninsured, and thus—at first blush—though the means may be different, the end is the same. Additionally, the political climate in Tennessee is such that a public plan dressed in private plan clothes may be the only way that a Medicaid expansion can happen in the State.⁹⁵ However, as is often the case, the devil is in the details. The remainder of this section will discuss the components of the Tennessee Plan, and where necessary offer critiques and provide recommendations for moving forward.

Before we break down the components of this request, a few general comments about the framework are necessary. The way the components are listed in the letter might suggest they bear equal weight and significance, but this appearance is misleading. The first concession requested by Governor Haslam would be the backbone of a Tennessee 1115 waiver proposal. The commercial insurance alternative to the Medicaid expansion *is* the novel and experimental program that Tennessee would be testing. The remaining requests, especially numbers two through four—even if novel in their own right—are simply smaller components of a commercial insurance alternative. The next section will briefly address the larger concept of a private pay alternative and then provide a more detailed discussion of the individual components of this alternative plan.

B. Sunset Clause and Payment Reform

The last two requests on the list submitted by Governor Haslam—a circuit breaker and provider payment reforms—warrant less attention than the other requested concessions, and for purposes of this Article, a brief discussion will suffice. First, from a budgetary standpoint, Tennessee's request makes little sense, as the amount of federal funding that accompanies a Medicaid expansion will likely create a budget surplus beyond the first three years when the expansion is fully funded.⁹⁶ Nevertheless, three years of coverage for the currently uninsured is better than the alternative, which is absolutely no coverage for this population. The sunset provision also complies with the requirement that 1115 waivers be limited in duration.⁹⁷ Accordingly, the inclusion of a sunset clause should not be viewed as a barrier in the waiver approval process.

95. See Abby Rapoport, *The Conservative Plan for Medicaid Expansion*, THE AMER. PROSPECT (Sept. 19, 2013) <http://prospect.org/article/conservative-plan-medicaid-expansion>.

96. *Briefing Paper: TennCare/Medicaid Expansion*, NASHVILLE AREA CHAMBER OF COMMERCE (Feb. 5, 2013), <http://nashvillepost.com/sites/default/files/attachments/73215/2013%2002%20Chamber%20Medicaid%20expansion.pdf> (describing additional revenues that will result from expansion funding, including, *inter alia*, revenues from the HMO tax).

97. 42 U.S.C. § 1315(a).

Second, although Tennessee's proposal does not provide a great deal of specificity with respect to payment reform, this lack of specificity should not serve as barrier for waiver approval either. In his March 27 address before the Tennessee Legislature, Governor Haslam stated the following: "During that period when our costs are covered 100 percent by the federal government, we'd work with our medical care providers to implement true payment reform. I am confident that working together, we could truly reduce medical costs."⁹⁸ Tennessee has a long history with provider payment reform. In fact, the State's first 1115 waiver, which created one of the first Medicaid managed care programs in the country, was a dramatic and novel form of provider payment reform.⁹⁹ With the important caveat that provider payment reform should not impact the quality of care provided to the beneficiary, this request is unobjectionable. In fact, it is arguably aligned with the larger goals of the Affordable Care Act,¹⁰⁰ and, as implied by Governor Haslam's letter to the Secretary, could likely be done even absent an 1115 waiver.¹⁰¹

C. Medicaid Benefits

In his April 1, 2013 letter, Governor Haslam requested, *inter alia*, approval from the Secretary for the following condition: "The Medicaid Expansion group will be treated the same as others enrolled in the [marketplace plans]. They will have access to the same benefits and appeals process as all other enrollees in these plans."¹⁰² Though this request might appear innocuous and perhaps even "reasonable,"¹⁰³ it threatens to undermine the health care services available to a poor and vulnerable population that is now a statutorily defined Medicaid population.¹⁰⁴ The Supreme Court's decision did not strike down this eligibility category; it simply removed the penalty that could be levied against states for their

98. Bill Haslam, Governor of Tenn., Remarks to the Tenn. General Assemb. (Mar. 27, 2013), https://news.tn.gov/sites/default/files/032713_Tennessee%27s_Plan_for_Health_Care_Reform_-_As_Prepared.pdf [hereinafter Haslam Remarks].

99. Jean I. Thorne et al., *State Perspectives on Health Care Reform: Oregon, Hawaii, Tennessee and Rhode Island*, 16 HEALTH CARE FINANCING REV. 121, 121–38 (1995).

100. See, e.g., Patient Protection and Affordable Care Act, Pub. L. No. 111-148 §§ 3008(a) (124 Stat. 376–77), 3022 (124 Stat. 395–99), 3025(a) (124 Stat. 408–13) (providing examples of provider payment initiatives included in the Act).

101. Haslam Letter, Apr. 2013, *supra* note 84 ("In addition to the commitments we are seeking from HHS, the Tennessee Plan includes reforming provider incentives and moving toward a value-based purchasing system that will reward results and help control costs.").

102. *Id.*

103. Haslam Remarks, *supra* note 98 ("All we're asking from Washington is to allow us to use the funds to provide coverage on the health care exchange in the same way many other Tennesseans will access coverage whether or not we expand. It's a reasonable ask [sic].").

104. 42 U.S.C. § 1396a(a)(10)(viii).

failure to recognize this category.¹⁰⁵ However, if a state accepts federal funds for this eligibility category, or any other, that state must comply with federal Medicaid law.¹⁰⁶ Thus, individuals who are not otherwise eligible for Medicaid and are living at or below 133 percent of the federal poverty line *are Medicaid beneficiaries*, and are thus entitled to the full scope of benefits and protections afforded to them under Medicaid law.

The Secretary has issued guidance to this effect.¹⁰⁷ On March 29, 2013, as support for a commercial insurance alternative began to swell in some states, the Secretary issued a short memo in the form of “Frequently Asked Questions,” or “FAQs,” that provided guidance to states that were working to develop alternative plans.¹⁰⁸ This memo clearly states that “beneficiaries remain Medicaid beneficiaries and continue to be entitled to all benefits and cost sharing protections.”¹⁰⁹ Further, the Secretary advised that “[s]tates must have mechanisms in place to ‘wrap-around’ private coverage to the extent that benefits are less and cost sharing requirements are greater than those in Medicaid.”¹¹⁰ Having issued this guidance, the Secretary is theoretically constrained from reversing course.¹¹¹ Accordingly, states seeking approval of 1115 waivers for alternative expansion plans should heed the guidance provided in the March 29 FAQs.¹¹²

Two Medicaid benefits in particular warrant additional examination. Though descriptions of the Tennessee Plan have been notably circumscribed, one can readily compare the mandatory benefits that must be provided to all Medicaid beneficiaries with the essential health benefits that are required for all plans sold on the marketplace.¹¹³ Two important mandatory Medicaid services that would likely be excluded in the Tennessee Plan’s waiver proposal are EPSDT and non-emergency transportation. Our recommendations with respect to these services will be addressed in turn below.

105. *NFIB v. Sebelius*, 132 S. Ct. 2566, 2608 (2012).

106. *Alexander*, 469 U.S. at 289.

107. *Medicaid and the Affordable Care Act: Premium Assistance*, U.S. DEP’T OF HEALTH & HUMAN SERVS. (Mar. 29, 2013), <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>.

108. *See id.*

109. *Id.*

110. *Id.*

111. *Motor Vehicle Mfrs. Ass’n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 41 (1983) (citing § 5 U.S.C. § 706(2)(A); *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 414 (1971); *Bowman Transportation, Inc. v. Arkansas-Best Freight System, Inc.*, 419 U.S. 281 (1974)) (noting that informal rules can be set aside only if “found to be ‘arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law’”).

112. *See* U.S. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 107.

113. *Compare* 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(1)–(5), (17), (21) and 42 C.F.R. § 431.53 (2012), with *Tennessee—State Required Benefits*, CENTERS FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/tn-state-required-benefits.pdf> (last visited Feb. 25, 2014).

1. EPSDT

The EPSDT requirements were incorporated into the Social Security Act as part of the 1967 Social Security Act Amendments.¹¹⁴ The program, which was recommended by President Lyndon Johnson, was designed to meet the unmet medical needs of millions of America's children—unmet needs that were creating a population of unnecessarily disabled adults.¹¹⁵ The broad, comprehensive, and mandatory requirements of the EPSDT program¹¹⁶ have made it “the single most important public policy effort ever undertaken to define an appropriate health services coverage standard embedded in developmental pediatric practice.”¹¹⁷ As one Tennessee court has described:

EPSDT covers a broad range of services. As the name suggests, the purpose of EPSDT is to ensure that all Medicaid-eligible children receive regular screening, vision, hearing, dental and treatment services consistent with established pediatric standards. The Federal Code requires that the children receive ‘such other necessary health care, diagnostic services, treatment and other measures . . . to correct or ameliorate defects and physical and mental illnesses under the State plan.’ 42 U.S.C. § 1396d(r)(5). The purpose of EPSDT is to ensure that underserved children receive preventive health care and follow-up treatment. EPSDT is premised on the idea that early detection of problems will lead to treatment of minor problems before they become major healthcare issues. By preemptively screening, diagnosing and treating current problems, EPSDT staves off larger healthcare problems in the future, and ultimately results in a more efficient and effective healthcare system with a proactive, comprehensive, and long-term focus.¹¹⁸

As noted above, though health plans on the marketplace are required to offer a core group of benefits,¹¹⁹ their coverage will not be as

114. Social Security Amendments of 1967, Pub. L. No. 90-248, 81 Stat. 821 (codified as amended at 42 U.S.C. §§ 701-731, 1396d).

115. LYNDON JOHNSON, WELFARE OF CHILDREN, H.R. Doc. No. 90-54 (1st Sess. 1967).

116. *See, e.g.*, John B. v. Menke, 176 F. Supp. 2d 786, 790 (M.D. Tenn. 2001).

117. Sarah Rosenbaum et al., *EPSDT at Forty: Modernizing a Pediatric Health Policy to Reflect a Changing Health Care System*, 3 (July 2008), http://www.chcs.org/usr_doc/EPSDT_at_40.pdf.

118. *Id.*

119. *See* CENTERS FOR MEDICARE & MEDICAID SERVS., *supra* note 113.

extensive as what is required by EPSDT.¹²⁰ Approximately 750,000 children in Tennessee are eligible for EPSDT services through the TennCare program.¹²¹ Thus, EPSDT is an enormously important program for Tennessee’s children. An EPSDT waiver puts health of Tennessee’s children in jeopardy, runs counter to the guidance provided by the Secretary, and should not be a part of a Tennessee 1115 waiver application.

2. Non-emergency Transportation

Federal law requires state Medicaid programs to provide non-emergency transportation to certain qualified Medicaid enrollees—for example, children and families who need transportation to access EPSDT services.¹²² While transportation is not explicitly mentioned in the Social Security Act, it is an administrative requirement created by the Secretary,¹²³ which has the force of law.¹²⁴ When the issue of transportation was raised in the U.S. District Court for the Middle District of Tennessee, that court noted the following about sub-regulatory guidance that has been offered by the Secretary about the transportation assurance regulation:

The Secretary of HHS has interpreted the application of the transportation assurance regulation, which has the force of law, in the *Medical Assistance Manual* (MAM). According to the MAM, the transportation requirement is an integral component of a statutory scheme whose aim is to further the federal government’s commitment to ensure adequate medical care for the needy. In the MAM, the Secretary points out that ‘the Medicaid program has, from the beginning (1966), encouraged [s]tates to arrange for transportation for recipients to and from necessary medical care.’ The regulation requiring the assurance of transportation is ‘based on the recognition, from past program operation experience, that unless needy individuals can actually get to and from providers of

120. This disparity is significant for purposes of our argument, but historically unremarkable. See Rosenbaum et al., *supra* note 117, at 1 (noting that EPSDT has traditionally provided a more comprehensive benefits package than private insurance plans).

121. John B. v. Emkes, 852 F. Supp. 2d 957, 961 (M.D. Tenn. 2012).

122. See 42 C.F.R. § 431.53 (2011).

123. See *id.*

124. Agency regulations have the “force and effect of law.” *Chrysler Corp. v. Brown*, 441 U.S. 280, 295–96 (1979); see also *Smith v. Vowell*, 379 F. Supp. 139, 148 (W.D. Tex. 1974) (“[T]here can be no question as to the authority of the regulations promulgated” by the agency regarding administration of the Medicaid program.), *aff’d*, 504 F.2d 759 (5th Cir. 1974).

services, the entire goal of a [s]tate Medicaid program is inhibited at the start.¹²⁵

As the language from the Secretary suggests, transportation is a vital component of ensuring that low-income individuals can actually access the care to which they are entitled. It is so vital in fact, that denying transportation services would defeat “the entire goal of a [s]tate Medicaid program.”¹²⁶ Section 1115 waivers must, as a matter of federal law, be used to test programs that promote the objectives of the Medicaid program.¹²⁷ It is difficult to imagine what experimental value a denial of transportation services could provide and such a denial is clearly at odds with the goals of Medicaid. Accordingly, such a waiver request would be detrimental to Tennessee citizens, is likely to be denied by the Secretary, and should not be included in a Tennessee 1115 waiver proposal.

D. Medicaid Protections

The Tennessee Plan must incorporate adequate protections of the expansion population for the Secretary to approve its program. Two areas of the Tennessee Plan in particular raise possible problems. The first subsection identifies economic inequalities in the cost-sharing program as well as the burden of the State to demonstrate the novelty of the cost-sharing program. The second subsection addresses the due process of Medicaid beneficiaries and the necessary considerations an alternative plan must contemplate.

1. Cost-Sharing

In his March 29, 2013 speech, Governor Haslam intimated that he would request waiver approval from the Secretary for cost-sharing provisions that would—absent a waiver—conflict with federal law. At the time, he listed this request as a potential barrier to an agreement between HHS and the State of Tennessee:

HHS says we have to provide additional benefits, above and beyond what everyone else in the exchange will receive. We’ll also have to follow certain Medicaid-driven guidelines when it comes to co-pays and the appeals

125. *Daniels v. Tenn. Dep’t of Health & Env’t*, No. 79–3107, 1985 WL 56553, at *2 (M.D. Tenn. Feb. 20, 1985) (citations omitted); *see, e.g., Vowell*, 379 F. Supp. at 148; *Fant v. Stumbo*, 552 F. Supp. 617, 619 (W.D. Ky. 1982) (finding that “any regulation which seeks to limit transportation for *necessary* medical treatment is contrary to the federal statutes and regulations and is thus invalid”).

126. *Daniels*, 1985 WL 56553, at *2.

127. 42 U.S.C. § 1315(a).

process instead of allowing these individuals to be treated like everyone else in private insurance plans.¹²⁸

Nevertheless, this request appeared in the list of concessions mentioned in the State's April 1 letter.¹²⁹ Specifically, Governor Haslam requested permission to implement "[c]ost sharing requirements for the Medicaid Expansion group [that] will be the same as other enrollees in the market place with incomes below 250 percent of poverty."¹³⁰ The Governor stated that his cost-sharing plan is designed to ensure that "the user has some skin in the game when it comes to health care incentives."¹³¹

As described above, the Social Security Act imposes additional, more stringent requirements on proposals seeking waiver of federal cost-sharing limitations.¹³² Though the nuances of federal cost-sharing requirements are beyond the scope of this Article, in broad terms only "nominal" co-pays can be assessed against the categorically needy,¹³³ which now includes the expansion population, and several categories and services are excluded from deductibles, co-pays, and other payments, including pregnancy-related services¹³⁴ and treatment provided to children pursuant to EPSDT.¹³⁵

From an economic perspective, this request makes little sense. It would impose co-pays on individuals making between zero and \$15,281.70 per year at the same levels as those making at least twice as much, \$28,725.¹³⁶ Given the high cost of the co-pays (equal to those levied against individuals at 250 percent of the federal poverty line), it is unlikely that this program could provide "benefits that aren't outweighed by risks to beneficiaries."¹³⁷ Additionally, as noted above, "[a] simple benefits cut, which might save money, but has *no research or experimental goal*, would not satisfy this requirement."¹³⁸ Though more details may emerge, Governor Haslam's stated justification seems unlikely to satisfy the

128. Haslam Remarks, *supra* note 98.

129. Haslam Letter, Apr. 2013, *supra* note 84.

130. *Id.*

131. Haslam Remarks, *supra* note 98.

132. In order for a waiver of these requirements to be approved, a state must demonstrate to the Secretary, *inter alia*, that its cost-sharing program (1) tests a unique and "previously untested" use of cost-sharing; (2) provides benefits that are not outweighed by risks to beneficiaries; (3) is based on a reasonable hypothesis that will be tested in a "methodologically sound manner"; and (4) is voluntary or contains provisions to address any damage to beneficiary health as a result of mandatory participation. 42 U.S.C. § 1396o(f).

133. 42 U.S.C. § 1396o(a); 42 C.F.R. § 447.53 (2011).

134. 42 U.S.C. § 1396o(a)(2)(B); 42 C.F.R. § 447.53(b)(2).

135. 42 U.S.C. § 1396o(a)(2)(A); 42 C.F.R. § 447.53(b)(1).

136. 2013 *Poverty Guidelines*, U.S. DEP'T OF HEALTH & HUMAN SERVS., <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Downloads/2013-Federal-Poverty-level-charts.pdf> (last visited Feb. 25, 2014).

137. 42 U.S.C. § 1396o(f).

138. *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994) (emphasis added).

requirement that a cost-sharing program has research or experimental value. Additionally, as one court has noted, “[O]ver the last [thirty-five] years, a number of studies have looked at the effects of cost sharing on the poor. Of all forms of cost sharing, copayments are the most heavily studied.”¹³⁹ Because “new” cost-sharing approaches have been tried for over thirty-five years, at this point it is hard to imagine a novel program that would have true experimental value. Further, the body of research that has emerged from these experimental projects demonstrates that cost-sharing is an ineffective and detrimental way to manage care for low-income patients,¹⁴⁰ which would make it difficult for Tennessee to demonstrate that this cost-sharing was not detrimental to enrollees.

Given both the economic inequity of the cost-sharing program proposed and the challenge of proposing a cost-sharing program that will test out a novel approach for managing health care delivery to low-income beneficiaries, the Secretary would be constrained in her ability to approve the program proposed by Governor Haslam.

2. Due Process

In his speech before the legislature, Governor Haslam also indicated that the Tennessee Plan would require a waiver of due process protections afforded to Medicaid beneficiaries.¹⁴¹ This request was repeated in his April 1, 2013 letter.¹⁴²

The due process rights of Medicaid beneficiaries are rooted in the Due Process Clause of the United States Constitution¹⁴³ and reinforced by the statutory language of the Social Security Act.¹⁴⁴ The breadth of these protections was given shape in the landmark case, *Goldberg v. Kelly*.¹⁴⁵ Under *Goldberg*, “when welfare is discontinued, only a pre-termination evidentiary hearing provides the recipient with procedural due process.”¹⁴⁶ This pre-termination hearing must take place before an impartial decision

139. *Newton-Nations v. Betlach*, 660 F.3d 370, 381 (9th Cir. 2011) (quoting the plaintiff’s public health expert’s statement); see, e.g., Robert H. Brook et. al, *The Effect of Coinsurance on the Health of Adults*, (Dec. 1984), available at <http://www.rand.org/content/dam/rand/pubs/reports/2006/R3055.pdf>.

140. Joseph P. Newhouse, *Consumer-Directed Health Plans and the RAND Health Insurance Experiment*, 23 HEALTH AFFAIRS 107, 109–10 (Nov. 2004), <http://content.healthaffairs.org/content/23/6/107.full.pdf> (highlighting the RAND finding that co-payments were harmful to the poor and sick).

141. Haslam Remarks, *supra* note 98.

142. Haslam Letter, Apr. 2013, *supra* note 84.

143. U.S. CONST. amend. XIV, § 1.

144. 42 U.S.C. § 1396a(a)(3) (requiring state plans to “provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness”).

145. 397 U.S. 254 (1970).

146. *Id.* at 264.

maker¹⁴⁷ after timely notice of the denial¹⁴⁸ and provide, *inter alia*, the opportunity to cross-examine adverse witnesses and have representation by an attorney, if the beneficiary so chooses.¹⁴⁹

In his letter to the Secretary, Governor Haslam requested permission to go forward with a waiver application that included a proposal that would treat the Medicaid expansion population “the same as all others enrolled in the [marketplace;] [t]hey will have access to the same . . . appeals process as all other enrollees in these plans.”¹⁵⁰ Though it is unclear what appeal procedures will be available in the marketplace, the Governor’s intent to seek a waiver to substitute those marketplace appeal procedures implies that they will be less robust than Medicaid’s procedures, since a waiver would only be required if the Tennessee Plan offered less protection to enrollees. Recall, however, that the scope of the Secretary’s waiver authority is limited. Though, as noted above, Section 1396(a) does include language about notice and a fair hearing, this is a supplement to—not independent of—the Due Process Clause of the United States Constitution. And, while the Secretary has authority to waive Section 1396(a) provisions, the Secretary cannot waive the Constitution; doing so would exceed the scope of her authority and subject a waiver program to judicial challenge. Accordingly, Tennessee, and other states considering an alternative to the Medicaid expansion must afford these categorically defined Medicaid beneficiaries with the full scope of due process protections as required by *Goldberg* and the United States Constitution.

CONCLUSION

By rendering the Medicaid expansion optional, the Supreme Court placed on the states the responsibility for addressing an enormous and inequitable hole in one of this country’s most important safety net programs. In his lead opinion, Chief Justice Roberts likened the ACA’s Medicaid expansion requirement to the federal government telling a state: “your money or your life.”¹⁵¹ Setting aside any disagreement with this characterization, it is clear that even if this premise can be accepted, the pendulum has swung too far in the other direction. If the proposals that

147. *Id.* at 271.

148. *Id.* at 267–69.

149. *Id.* at 269–70.

150. Haslam Letter, Apr. 2013, *supra* note 84.

151. *NFIB v. Sebelius*, 132 S. Ct. 2566, 2605 n.12 (2012). The use of the metaphor in the service of a ruling that has the effect of denying Medicaid coverage to the uninsured poor is tragically ironic. A well-documented deficiency of the American health care system that Medicaid expansion would address is the large number of Americans that cannot afford health coverage. For these unfortunate millions, “your money or your life” is a lived reality, not a rhetorical flourish. The Institute of Medicine places the number of preventable deaths among the uninsured, due to their inability to afford timely medical care, at 18,000 per year. COMMITTEE ON THE CONSEQUENCES OF UNINSURANCE, INSTITUTE OF MEDICINE, CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE 163 (2002).

have been presented to the Secretary—both the letter sent from Governor Haslam, and the formal proposals offered by Iowa and Arkansas—are any indication, several aspects of these alternative plans threaten to undermine the central goals of Medicaid, the fundamental purpose of the Section 1115 waiver program, and the spirit of cooperative federalism.

Tennessee is faced with the opportunity to right the inequity of archaic categorical Medicaid eligibility categories and provide coverage to over 160,000 uninsured Tennesseans.¹⁵² This opportunity comes with an unprecedented level of federal funding and a demonstrated willingness from the Secretary to consider experimental programs. To shift the pendulum back to center and ensure that expanded access to care can happen in Tennessee, the State must act in a manner that respects the shared goal of providing for the general welfare of Tennesseans. In short, it must cooperate.

152. *The Coverage Gap*, *supra* note 1, at 5.