Backgrounder

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Facing Obamacare: What the States Should Do Now

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Abstract: *The sweeping health care bill pushed by congressional Democrats and President Barack Obama has been signed into law. The enormous expansion of federal power that will result from "Obamacare" will have far-reaching effects on the traditional roles and authority of states—and on the freedoms of American citizens. When governors and state legislators realize that they have been reduced to mere tax collectors for the federal government, bipartisan opposition from the states will be inevitable. Former Director of the Center for Medicaid and State Operations at the U.S. Department of Health and Human Services Dennis Smith explains what states should do to protect their historic authority—and their citizens—from this power grab of one-sixth of the American economy.*

Congress and the Obama Administration are confronting the nation's governors and state legislators with new challenges to states' traditional authority—and with the difficult decision of whether accepting intrusive and unprecedented federal mandates is in the best interests of their citizens.

With passage of the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act, Congress and the Obama Administration have made extravagant promises to the American people. Many of the most high-profile promises—such as extending the life of the Medicare Trust Fund, allowing those who are happy with their health insurance plans to keep them, lowering the cost of health care, and not raising taxes on families

Talking Points

- Congress and the Administration have enacted a sweeping overhaul of one-sixth of the American economy, dramatically expanding the scope of federal power.
- With passage of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, Congress and the Administration have made extravagant promises to the American people.
- Based on the provisions of the new health care law, many of these promises, including lowering the cost of health care, simply cannot be kept.
- Failure to lower the cost of health care will become a justification for raising taxes and extending political control. Failure to meet public expectations will embolden those who favor a government "single-payer" health insurance monopoly.
- When governors and state legislators realize that they have been reduced to mere agents of and tax collectors for the federal government, bipartisan opposition from the states will be inevitable.

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with annual incomes below $250,000—will not be fulfilled.[1]

Based on the provisions of the new law, many of these promises simply *cannot* be kept. The reality is that the life of the trust fund cannot be extended while the federal government spends the money dedicated to it, Medicare Advantage enrollment will be cut in half, the cost of health care will *increase*, and the Department of Justice will end up defending the individual mandate on Congress's power to tax. It is as if official Washington promised the American people the fountain of youth and it was to be paid for with the proverbial pot of gold at the end of the rainbow.

While the White House would like to give the impression that the debate on health care is over, the truth is that it has just begun.

The bad news for states, as well as for the career public servants at the Centers for Medicare and Medicaid Services (CMS), is that they have been charged with spinning straw into gold. Perhaps for some Members of Congress, the failure of states and CMS staff is a viable, perhaps even desirable, option: Failure to lower the cost of health care will become a justification for raising taxes and extending political control. Failure to meet public expectations will embolden those in Congress and elsewhere who have long wanted a government health insurance monopoly, often called a "single-payer" health care system. The law itself, regardless of congressional intentions, is a blueprint for failure.

As states are faced with new challenges to their authority, unsustainable financial obligations, and a loss of managerial flexibility over Medicaid, the national health care debate has shifted to them. Fostering transparency, state officials can insist that federal officials explain themselves in the implementation of new rules and regulations, can initiate legal challenges to federal actions as they deem it necessary, and keep their citizens informed of developments in the implementation of the new law.

How states should react to the PPACA no doubt will become central to public debates in anticipation of the November elections, in which 37 gubernatorial offices will be placed before the voters. Meanwhile, Members of Congress should be encouraged to reconvene last summer's town hall meetings and listen to the citizens' pleas to repeal this mammoth and misguided law, start over, and get health care reform right.

While the White House would like to give the impression that the debate on health care is over, the truth is that it has just begun. Like welfare reform legislation in the past, there are really three phases to reform. An act of Congress is just the first; now reform passes to the state level and eventually to the local level, and it is at the state and local levels that the real impact on the country's citizens will become apparent.

While the White House wants to claim that any opposition stems from profiteering, it has ignored the fact that 85 percent of Americans already have health insurance and do not want to see it disrupted. Congress and the Administration have created a chain of events that will produce winners and losers relative to the current private-based system. Welfare reform legislation has survived for more than a decade because it was passed with overwhelming bipartisan support in Congress and had the support of the American people.

How the Federal Health Law Affects the States

The new law will weaken the states in a variety of ways:

Obamacare Strikes at Traditional State Authority. State officials face a dilemma of epic dimension because they have been forced into fighting for the traditional concept of federalism itself.

1. See Richard S. Foster, Chief Actuary, Office of the Actuary, U.S. Department of Health and Human Services, memorandum, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," April 22, 2010, at *http://thehill.com/images/stories/whitepapers/pdf/oact%20memorandum%20on%20financial%20impact%20of%20ppaca%20as%20enacted.pdf* (April 28, 2010).

The extent to which PPACA reduces the role of the states, with official Washington creating the impression that states are neither valued nor needed, is alarming. Throughout this new federal law runs a constant theme that the authority of the sovereign states can be overridden by the Secretary of the U.S. Department of Health and Human Services (HHS) or replaced by some nonexistent not-for-profit organization.

The misguided belief that a not-for-profit entity with no experience in the administration of public programs, with no financial stake of its own, and accountable to no one at the state level can be put in charge of spending state funds is absurd. Yet if states decline to establish their health insurance exchanges, they expose themselves to the financial uncertainty of inflated Medicaid rolls. If the Secretary of HHS runs the exchanges, for whom do state insurance commissioners work—the people who elected or appointed them to office or the federal government?

Obamacare Empowers Bureaucracy. New federal and state planning groups are popping up like dandelions. The first order of business at HHS, CMS, and among the states is to figure out how much money the bureaucracies need in order to implement PPACA.

Everyone from actuaries and attorneys to social workers and Web site managers is compiling resource wish lists. Senior officials at the federal and state levels realize that to meet the statutory deadlines, they are already at least six months behind schedule and are frantic to catch up.

States have been building Medicaid Management Information Systems (MMIS) for more than 40 years. Despite all this experience, it is still a five-year project from planning to certification of a wholly new system. If HHS chooses to micromanage each particle of the exchanges, failure is all but guaranteed simply because the regulatory and procurement process will force states to miss deadlines.

State officials continue to analyze the new law and are trying to estimate its likely fiscal impact on their states. Despite enhanced federal funding for new populations, states face tremendous fiscal pressures in meeting the needs of those who are currently eligible for assistance.

Just a year ago, Congress committed new funding for outreach to children who are currently eligible for Medicaid and the State Children's Health Insurance Program (SCHIP). Congress insisted at that time that millions of eligible children are not enrolled. There is no new federal funding for Medicaid children. How many currently eligible but unenrolled adults are there? States must absorb their share of the program for these individuals without new federal funding. The new law will result in current eligibles staying on Medicaid for a longer period of time. Again, there are no new funds for this type of caseload increase.

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Unless states commit more of their resources to provider reimbursement, millions of current and new Medicaid enrollees will not have timely access to appropriate medical services, as the CMS actuary has pointed out. A cynic might suspect that such a failure would provide perfect justification for even more direct federal control accompanied by higher taxes and new spending.

State officials are grappling with organizing their decision-making process to determine their resource needs, which optional Medicaid changes they should adopt, and what new grant programs or demonstrations they should pursue. States have billions of dollars at stake in how the maintenance-of-effort (MOE) requirements are interpreted. Funding will depend on the definitions of income, family size, and taxpayers.

The fiscal impact analysis is even more complicated for states with comprehensive Section 1115 Demonstration Projects (familiarly known as "1115 waivers"). The MOE requirements appear to be contradictory in dealing with waivers.

As a fundamental condition of these waivers, they must be budget neutral to the federal government. If states are forced to provide full Medicaid benefits and reduce cost-sharing, it is unlikely the waivers will be budget neutral, requiring their termination. There is a financial risk for states as budget neutrality is enforced by requiring states to return any excess

federal funds (i.e., actual expenditures that are greater than projected expenditures). As savings under waivers generally build up over time, states will lose their budget neutrality cushion.

Moreover, under standard terms and conditions of a waiver, states are required to notify the federal government six months before the end of a waiver. This could require states to terminate waivers before 2014 when the new subsidies become available, causing the lost of current coverage.

State officials often seek federal 1115 waivers for Medicaid, giving them more managerial flexibility. These are particularly popular because they are homegrown. The federal preemption will be controversial, and state officials rightfully will need to manage expectations about why the waiver must be ended. It is unlikely that any state will take the risk of repaying funds to the federal government, which in turn would jeopardize the funding of other state priorities such as education, transportation, and public safety.

A Financial Crunch Is Inevitable. Money will be the crucial issue for many state officials. Will the enhanced federal funding for some primary care service codes backfire on states by creating pressures to increase payment to other providers and services? What happens when the temporary funding expires? Has Congress re-created a "doc fix" in Medicaid?

States will be forced to spend substantial funds to reprogram computer systems to track new eligibility groups and match rates.

Medicaid officials understand what Congress does not: The biggest gaps in access are among specialists, not in primary care. States will be forced to spend substantial funds to reprogram computer systems to track new eligibility groups and match rates.

States face new costs for provisions that had little if any congressional discussion, such as those about the application of spousal impoverishment rules to new populations. Will the backroom deal on prescription drugs reduce the rebates paid to states that are considered to be revenue? Will the young, healthy folks show up to stabilize the coverage pool, or will adverse selection increase Medicaid costs?

There are potential ways in which the cost to states may be reduced, and they will be surprising to the law's supporters. For example, the number of children on SCHIP should decline dramatically beginning in 2014. As their parents become insured and have access to family coverage, millions of children will no longer be eligible for SCHIP, and this will create savings for states.

States should also view the role of exchanges in determining Medicaid eligibility as an opportunity to privatize the eligibility process and downsize the numbers of state and county eligibility workers. The administrative costs of eligibility are allocated among Medicaid, the Supplemental Nutrition Assistance Program (SNAP, formerly the Food Stamp Program), and other welfare programs. If Medicaid costs are absorbed by the exchange, costs will shift from states to the federal government as SNAP, the second-largest welfare program involved in administrative cost allocation, is forced to pick up a greater share of the administrative costs.

New Strings Are Attached. The new federal funds come with yards of strings attached that threaten to strangle states. States need to consider whether the benefits outweigh the costs if they participate. This begins with explaining to the public what those strings are.

For example, while the federal government has provided $5 billion to fund high-risk insurance pools, states accepting such funds may be disadvantaged through funding allocation and the maintenance of effort requirements. States have to agree to federal terms that are as yet undefined. On the other hand, there is no financial risk to not participating in this temporary program.

What States Should Do Now

The Kaiser Family Foundation reports that more than half of Americans are confused about what the new health care law means for them.[2] State officials are going to do what is in the best interests of their citizens and try to provide the much-promised transparency that was notoriously absent during the congressional process. They can do this in a variety of ways.

1. **Make federal officials explain themselves in broad daylight.** State officials, including state legislators, should convene public hearings and insist that federal officials appear to answer state concerns. Federal officials obviously control the regulatory process, but states should demand, individually and collectively, that the federal government respond to their priorities.

   The Obama Administration, for instance, has rescinded regulations on Medicaid benchmark plans and cost-sharing and has yet to propose new rules. This leaves states to rely solely on the statute, which actually may provide greater flexibility than what might be allowed through rule-making, but states also do not want to go down a blind alley. States should insist that HHS provide assurance that it will approve use of a benchmark plan that is designed according to the Medicaid statute.

2. **Insist on rational rule-making for Medicaid.** States should insist that, instead of issuing a single, mammoth Medicaid rule, HHS should issue separate rules so that all issues will receive proper attention.

   The first rule should be on the maintenance-of-effort requirements and the interactions with the rest of the new law. Congress imposed an MOE to prevent states from dropping current eligibility levels and changing eligibility determination rules. Under Medicaid, states are *required* to cover certain populations and *allowed* to extend coverage to others. If states were to drop the optional populations, they would become eligible for the new federal subsidies, which would increase the previously projected cost to the federal government.

   The MOE applies to "standards and methodologies," which refers to such questions as how eligibility is determined, how often it is redetermined, and what is counted as income. The MOE is critical to states so that they can evaluate, respond, plan, and budget accordingly. The MOE should not apply to benefits and should not prevent a state from switching from Medicaid to SCHIP.

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3. **Take the Feds to court, if necessary, to protect state interests.** States should challenge HHS whenever it undermines state authority. Under the American Recovery and Reinvestment Act (ARRA), HHS extended MOE requirements beyond eligibility to include cost-sharing. There was no statutory basis for such an overreaching interpretation. Prohibiting a state from increasing cost-sharing for a brand-name drug by 50 cents in order to encourage the use of generics is contrary to the types of changes that will be needed to lower the overall cost of health care.

4. **Keep citizens fully informed every step of the way.** State officials have an obligation to fully explain the impact of this new law on their citizens and create the public forum for holding federal officials accountable. State officials need to explain the new financial inequities that will be created among families. They need to explain the connection between increased Medicaid costs and decreased resources for education and other state priorities. Every line of the new law must be examined as a mason examines each brick to be laid.

Conclusion

Congress and the Administration have enacted a sweeping overhaul of one-sixth of the American economy and in doing so have dramatically expanded the reach and scope of federal power. This federal expansion is a direct challenge to the traditional authority of the states.

The federal government has provoked state resentment in symbolic ways as well. Congress dropped the word "State" from the popular State Children's Health Insurance Program. The Obama Administration has dropped "State" from the title of

2. Henry J. Kaiser Family Foundation, "Public Opinion on Health Care Issues," Kaiser Health Tracking Poll, April 2010, at *http://www.kff.org/kaiserpolls/upload/8067-F.pdf* (April 26, 2010).

the center that directs Medicaid. Under a new reorganization, it is no longer the Center for Medicaid and State Operations (CMSO), but the Center for Medicaid, CHIP, and Survey and Certification—as if states no longer existed.

When governors and state legislators realize that they have been reduced to mere agents and tax collectors for the federal government, bipartisan opposition from the states will be inevitable. At that point, the political momentum for repeal of the current law will build, and Congress and the states—as partners, not opponents—can start over and get health reform done right.

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