Bloomberg BNA

Health Insurance Report™

VOL. 0, NO. 0 AUGUST 22, 2012

Key Factors That May Influence a State's Decision Whether to Expand Its Medicaid Population Under ACA



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Speculation abounds with respect to the decision states will make on the issue of whether to expand Medicaid coverage under the Affordable Care Act (''ACA''),[1] now that the Supreme Court of the United States (the ''Court'') has made the option to abstain a meaningful one.[2] This article highlights some key factors that may influence a state's decision whether to implement such an expansion.

In order to expand health coverage and make some attempts at reducing health care costs, the ACA implements a myriad of provisions that increase the federal government's role in the health care delivery and health

[1] The term Affordable Care Act refers to federal health reform in its present state, taking into account the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as well as the subsequent changes in the Health Care and Education Reconciliation Act, Pub. L. No. 111-152.

[2] *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

 ISSN 2154-8986

insurance benefits sectors; historically, the purview of mostly state regulation. One provision recently subjected to constitutional scrutiny includes the individual mandate for private citizens to purchase or obtain health benefits coverage or face a penalty.[3] The Court also reviewed the criteria for expanding Medicaid coverage to new eligibles in the states.[4] This Article focuses on the impact of the Court's decision on the latter issue, i.e., Medicaid expansion. The ACA was opposed by 26 states before the Court,[5] and the Republican-led House of Representatives has voted to repeal or defund the law 31 times.[6] Statistics such as these disclose the high level of resistance to adoption of the ACA. Consequently, it is not surprising that states are seriously weighing the Medicaid expansion option.

In understanding the impact of the Court's holding, it is important to recognize the parallel roles that both provisions were crafted to serve. The individual mandate was included in the ACA to increase covered lives by imposing a penalty on individuals that decline to obtain health insurance, although the effectiveness of the penalty remains uncertain.[7] The Medicaid expansion was included in the ACA to provide safety-net coverage to a wider population of low-income individuals, including childless adults that are currently excluded from the original Medicaid program. States were encouraged to expand their Medicaid population through the provision of fairly generous, although not long-term guaranteed, federal funding for this expanded population.[8] Additionally, the consequence of declining Medicaid expansion, beyond the loss of federal funding for this population, was supposed to be the forfeiture of preexisting federal Medicaid funds for the original Medicaid program.

Prior to the Court's ruling, the Congressional Budget Office (''CBO'') and the Joint Committee on Taxation had predicted that the penalty of forfeiture of preexisting federal Medicaid funds would effectively force all states to participate in this expansion. Significantly, the Court's ruling now provides states with a more meaningful choice where there was not one before the Court's ruling: accept federal funding and expand Medicaid, or decline federal funds for this population but maintain their original Medicaid program.

The evolution of health care entitlement programs provides insight into the potential impact that this new state Medicaid option may have on future state budgets. By way of background, Medicare and Medicaid found their inception in the Social Security Amendments of 1965, which sought to provide health benefits for the elderly and indigent families with children. The nation's economy was several decades removed from the Great Depression. There was a political compromise to address access to health benefits for the most vulnerable populations—people aged 65 and older as well as indigent families—each is unlikely to obtain health insurance through an employer. While Medicare is a federal social insurance program, Medicaid is a state-run program funded in part by state funds and in part by federal funds. The federal government establishes numerous standards and oversight of the state-administered Medicaid programs.

In 1966, the federal government introduced the Medicaid program by providing at least 50 percent federal matching funding to the states with voluntary state enrollment. The social debate was similar to that surrounding the current deliberation; state governors weighed the benefit of federal matching dollars against the drawback of putting state money into a new entitlement program that included federal involvement.[9] Six states entered initially, but 27 more states started Medicaid programs before 1966 had come to a close.[10]

By 1970, the attractions of federal funding overcame holdouts, and all states but Arizona had joined. Arizona declined the Medicaid program and instead left indigent health care decisions to its individual counties. Over time unrest grew amongst certain Arizona stakeholders, and a petition began to circulate to commence the legislative initiative process to approve a Medicaid program in Arizona.[11] The movement garnered support and, rather than be subject to the legislative initiative process, the Arizona state government eventually took action and finally started a Medicaid program in

[3] 26 U.S.C. § 5000A(b)(1).

[4] 42 U.S.C. § 1396c.

[5] Phil Galewitz & Marilyn Werber Serafini, *Ruling Puts Pressure On States To Act*, KAISER HEALTH NEWS (June 28, 2012, 7:50 PM), http://www.kaiserhealthnews.org/Stories/2012/June/29/state-medicaid-program-growth-chart.aspx (including 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).

[6] *Should Congress Repeal the Affordable Care Act?*, U.S. NEWS & WORLD REPORT, http://www.usnews.com/debate-club/should-congress-repeal-the-affordable-care-act.

[7] Indeed, it is precisely the mildness of the penalty that saved the ACA constitutionally; according to the majority opinion, when faced with the choice it might ''often be a reasonable financial decision to make the payment rather than purchase insurance.'' *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2596.

[8] Prior to the Court's holding, an actuarial report from the Centers for Medicare & Medicaid Services estimated that enrollment in traditional Medicaid would remain fairly stable, between 56 million and 57 million annually, in 2011, 2012, and 2013; the report projected enrollment to grow by more than 14 million in 2014, after the Medicaid expansion went into effect. 2011 ACTUARIAL REPORT ON THE FINANCIAL OUTLOOK OF MEDICAID, CTRS. FOR MEDICARE & MEDICAID SERV. 19, tbl. 3 (2012), *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/MedicaidReport2011.pdf.

[9] Sarah Kliff, *Medicaid Expansion Poses a Familiar Face-Off*, THE WASHINGTON POST, July 9, 2012, http://www.washingtonpost.com/business/economy/medicaid-expansion-poses-a-familiar-face-off/2012/07/09/gJQAhtqCZW_story.html; *see also* David Leonhardt, *Republicans and Medicare: A History*, N.Y. TIMES ECONOMIX BLOG (Oct. 21, 2010, 10:00 AM) http://economix.blogs.nytimes.com/2010/10/20/republicans-and-medicare-a-history/.

[10] Kliff, *supra* note 10.

[11] The legislative initiative process is a ''proposal of a new law or constitutional amendment that is placed on the ballot by petition, that is, by collecting signatures of a certain number of citizens. A total of 24 states have the initiative process. Of the 24 states, 18 allow initiatives to propose constitutional amendments and 21 states allow initiatives to propose statutes. In most cases, once a sufficient number of signatures has been collected, the proposal is placed on the ballot for a vote of the people.'' *What are ballot propositions, initiatives, and referendums?*, INITIATIVE & REFERENDUM INST., UNIV. OF S. CAL,, http://tinyurl.com/6cwfbn.

  HIR ISSN 2154-8986

1982—16 years after its federal enactment.[12] Significantly, by that time Arizona used a statewide waiver mechanism so that its program utilized managed care plans and forewent the traditional and potentially more inefficient fee-for-service model.

The State Children's Health Insurance Plan (''CHIP''), passed in 1997, also gave states the option to accept some federal funding in exchange for covering certain additional vulnerable patient populations.[13] CHIP provides federal funding to help states cover children in families unable to afford health insurance but also ineligible for Medicaid. The introduction of CHIP was under different circumstances. The economy was booming, and states were in the midst of adopting independent spending programs to provide for this population. CHIP provided the states with some administrative discretion while the federal government paid a greater share than it did for Medicaid.[14] Texas was the last state to join, but all states had done so within three years of the program launching. Both the Medicaid and CHIP program launches provide similar, although not identical, circumstances to the present option for Medicaid expansion. Significant factors influencing the rate of state participation include: (1) the national and local political climate; (2) the status of the economy; (3) the legislative power of individual constituents; and (4) the amount of federal funding and the accompanying federal interference with state operators and state fiscal status.

1. Political Context

There is a belief that a change in party leadership at the White House will heighten the probability that these Medicaid expansion programs will carry less stringent federal requirements in a Republican administration. For example, Republican governors in Tennessee, Alabama, Kansas, Indiana, Georgia, Oklahoma, Iowa, South Dakota, Utah, Pennsylvania, and Idaho are counting on a Republican administration and have stated publicly that November will be the earliest point at which they will make a decision regarding whether to expand their current Medicaid programs.[15] Republican leaders that decried the ACA as unconstitutional have been given an opportunity to decline participation in expanding Medicaid of their own volition.[16] Much depends upon the political strength of the various constituencies, e.g., those concerned with fiscal responsibility and control over their state's budget (especially where there are balanced budget requirements) versus those concerned with access to health benefits for a portion of the state's population.

There will be substantial lobbying efforts from health care providers that continue to deliver uncompensated care to the uninsured.[17] Furthermore, several states opposed to expanding Medicaid are home to some of the largest uninsured populations.[18] Republican Gov. Rick Perry in Texas, for example, has declared that Texas will not accept federal funds for Medicaid expansion in Texas at this time. Texas also leads the nation in percentage of uninsured individuals.[19] The federal share of Medicaid funding comes from United States' general revenue. Therefore, there is likely to be pressure from some constituents in states that reject expansion as their federal tax payments go to benefit other states that do expand their Medicaid population. Alternatively, there may be lessons to be learned so that states that elect to expand Medicaid in later years can avoid mistakes from the states that expand immediately.

The federal government has expressed some flexibility with respect to states' decisions. The Obama Administration declared recently that there is no deadline to announce participation in Medicaid expansion, and any funding received by states to build out other areas of reform, such as health insurance exchanges, will not need to be returned if those states later decide not to participate in a Medicaid expansion.[20]

In addition, Medicaid Director Cindy Mann recently announced in a presentation at a meeting of the National Conference of State Legislatures that states who do expand their Medicaid population can later decide to drop the coverage without repercussions.[21] However, at this point in time the Obama Administration is not willing to approve the Medicaid expansion through federal funding in the form of block grants, as discussed below.[22]

2. Economic Impact

The status of local economies will be influential on a state's decision whether to expand its Medicaid program. Access to health benefits may be a desirable goal but it also has budgetary implications although billions of federal dollars are potentially available. Present guidelines for Medicaid coverage exclude a significant portion of the population. Under the ACA, expansion in 2014 requires that *all* individuals at or below 138 per-

[12] *History of Initiative and Referendum in Arizona*, BALLOTPEDIA (June 21, 2011, 9:24 AM), http://ballotpedia.org/wiki/index.php/History_of_Initiative_%26_Referendum_in_Arizona.

[13] *The State Children's Health Insurance Program*, CONG. BUDGET OFFICE, May 2007, http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/80xx/doc8092/05-10-schip.pdf.

[14] *See* Jeanne M. Lambrew, *The State Children's Health Insurance Program: Past, Present, and Future*, THE COMMONWEALTH FUND at 12 (Jan. 2007), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2007/Feb/The%20State%20Childrens%20Health%20Insurance%20Program%20%20Past%20%20Present%20%20and%20Future/991_Lambrew_SCHIP_past_present_future%20pdf.pdf.

[15] Kyle Cheney, *Waiting for Medicaid Decisions? Don't Hold Your Breath*, POLITICO PRO (July 26, 2012, 2:29 PM).

[16] Kyle Cheney, *GOP Governors Name Their Price on Health Care Law Expansion*, POLITICO PRO (July 14, 2012, 6:07 PM).

[17] *See* Jonathan Cohn, *New Republic: The Undermined Medicaid Expansion?*, Nat'l Pub. Radio (July 2, 2012), http://www.npr.org/2012/07/02/156105350/new-republic-the-undermined-medicaid-expansion.

[18] Christopher Sherman & Juan Carlos Llorca, *Working Poor Stand at Center of Medicaid Debate*, http://news.yahoo.com/working-poor-stand-center-medicaid-debate-180132517--finance.html

[19] *Health Coverage & Uninsured*, KAISER FAMILY FOUND., http://www.statehealthfacts.org/comparecat.jsp?cat=3 (listing Texas uninsured at 25 percent, far exceeding U.S. uninsured rate of 16 percent) (last visited Aug. 10, 2012).

[20] Letter from Marilyn Tavenner to Robert McDonnell (July 13, 2012), *available at* http://www.modernhealthcare.com/assets/pdf/CH80617713.PDF.

[21] Jennifer Haberkorn, *Mann: States Can Drop Medicaid Expansion*, POLITICO PRO (Aug. 7, 2012, 2:40 PM).

[22] *GOP Governors Name Their Price*, *supra* note 17.

cent of the federal poverty level be eligible.[23] From 2014 to 2016, the federal government will pay 100 percent of the costs for all patients enrolled in the expanded Medicaid program that were not previously eligible.[24] Required state contributions will begin after that point and increase gradually to a maximum 10 percent no earlier than 2020.[25]

Even with the maximum 10 percent state funding currently contemplated by the ACA, there is no guarantee that future Congresses, facing their own fiscal challenges, will not seek to shift more of the burden for the Medicaid expansion population onto the states. While the Medicaid program did not initially require a substantial level of state funding, state spending on the program has increased at a dramatic pace, accounting for 24 percent of total state spending in fiscal year 2011.[26]

The federal debt ceiling legislation passed in August 2011 will likely be addressed again as early as Congress' lame-duck session later this year. A major budgetary crisis, popularly referred to as the ''fiscal cliff,'' rapidly approaches. Cost-saving measures are vital to the country's financial sustainability.[27] Prior to the Court's ruling, the ACA was scored by the CBO as deficit-reducing reform over a 10-year period. The updated analysis revealed even greater savings as a direct result of the potential reduction in the number of states that will likely expand their Medicaid programs.[28] The Medicaid expansion is predicted to be reduced by as much as 45 percent.[29]

It is unclear at this time whether debt reduction, economic stimulation, entitlement reform, or a combination of any of the three will be front and center during the lame-duck session. Without the benefit of the results of the November elections, it also is unclear what the new Congress will prioritize, as that also affects state decisionmaking with respect to the Medicaid expansion option.

3. State Legislative Processes

As demonstrated in Arizona, the power of certain citizens to compel the creation of new state laws can be persuasive to a state government that holds a different viewpoint. Although such action is infrequent, the ability of certain motivated citizens to do so will be a consideration for any state government as it weighs the decision whether to expand its state's Medicaid program. Currently, 21 states allow the use of the initiative process to place a proposal for a new law on a ballot; among the 26 states that were a party to the Court case opposing the ACA, 14 recognize these citizen-initiated statutory initiatives.[30] In states currently governed by either a state house or a legislature unwilling to elect to expand Medicaid, individual citizens can take action by uniting at the ballot box and collectively attempt to force the hand of their state government through this initiative process.[31]

Where divided state legislatures fail to pass laws expanding Medicaid, it is possible that governors favoring it will issue an executive order for expansion.[32] Gov. Lincoln Chafee of Rhode Island, an independent and former Republican, provided an example when he created a health care exchange by executive order in response to the state legislature's failure to do so.[33] The expansion of Medicaid by executive order within a state is less likely because of the significant fiscal undertaking that it represents.

Finally, the timing of, and frequency with which, state legislatures meet is also capable of having a significant effect on whether a state chooses to expand its Medicaid program. Although the majority of state legislatures meet annually, the legislatures in Montana, Nevada, North Dakota, and Texas meet only biennially, holding their regular sessions in odd years.[34] With the exception of Montana, each of these states opposed the ACA.

Of course, there usually are some procedures for holding special sessions, but Medicaid expansion is slated to go into effect on January 1, 2014. In the absence of these states calling a special session of their state's legislature, the Medicaid expansion option will not even be addressed until a full year after it becomes available nationwide. This delay may weigh for or against Medicaid expansion depending upon an array of factors including the experiences of states that do expand Medicaid in 2014, the respective state budgetary

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[23] The ACA-established eligibility threshold is 133 percent; however, when calculating modified adjusted gross income, 5 percent of every individual's income is disregarded, making the effective rate 138 percent. CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 7 n.13 (2012), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf.

[24] *Id*.

[25] Philip Betbeze, *Sequestration Might Be Least Bad Outcome for Healthcare*, HEALTHLEADERS MEDIA (July 20, 2012), http://www.healthleadersmedia.com/page-2/LED-282544/Sequestration-Might-Be-Least-Bad-Outcome-for-Healthcare.

[26] *NGA, NASBO Say Medicaid Costs Growing, Fiscal Recovery Slow*, NAT'L GOVERNORS ASS'N (June 12, 2012) http://www.nga.org/cms/home/news-room/news-releases/page_2012/col2-content/nga-nasbo-say-medicaid-costs-gro.html; *see also* Phil Galewitz, *States Cut Medicaid Drug Benefits to Save Money*, KAISER HEALTH NEWS (July 24, 2012), http://www.kaiserhealthnews.org/stories/2012/july/25/medicaid-cuts-sidebar.aspx (noting the challenges states face in trying to pay for Medicaid and balance their budgets).

[27] Betbeze, *supra* note 26.

[28] ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS UPDATED FOR THE RECENT SUPREME COURT DECISION, *supra* note 24.

[29] *Id*.

[30] The fourteen states include Alaska, Arizona, Colorado, Idaho, Maine, Michigan, Nebraska, Nevada, North Dakota, Ohio, South Dakota, Utah, Washington, and Wyoming. *Signature, Geographic Distribution, and Single Source Requirements for Initiative Petitions*, INITIATIVE & REFERENDUM INST., UNIV. OF S. CAL., *available at* http://www.iandrinstitute.org/statewide_i%26r.htm.

[31] *See*, *What are ballot propositions, initiatives, and referendums?*, *supra* note 12.

[32] ''The authority for governors to issue executive orders is found in state constitutions and statutes as well as case law, or is implied by the powers assigned to state chief executives. Governors use executive orders—certain of which are subject to legislative review in some states—for a variety of purposes.'' *Governors' Powers and Authority*, NAT'L GOVERNORS ASS'N, http://www.nga.org/cms/home/management-resources/governors-powers-and-authority.html#executive.

[33] Michael Cooper, *Many Governors Are Still Unsure About Medicaid Expansion*, N.Y. TIMES (July 14, 2012) http://www.nytimes.com/2012/07/15/us/governors-face-hard-choices-over-medicaid-expansion.html?pagewanted=all.

[34] *Annual Versus Biennial Legislative Sessions*, NAT'L CONF. OF STATE LEGIS., http://www.ncsl.org/legislatures-elections/legislatures/annual-versus-biennial-legislative-sessions.aspx.

  HIR ISSN 2154-8986

considerations, and the party controlling the respective legislature in 2015.

4. Federalism Funding and Other Requirements of Expansion

Initial estimates anticipated that the Medicaid expansion would extend coverage to approximately 13 million people.[35] In some states, the total number of these people may be small. In other states, like Texas, the number may be quite large. Obviously, the larger the potentially affected population, the more difficult the Medicaid expansion decision is for a state. Given the current federal-state track record in the original Medicaid program, states recognize that federal money comes with federal controls. One issue voiced by many states relates to the continued viability of federal funding for the Medicaid expansion at the level currently required by the ACA.[36] Current federal Medicaid subsidy levels are at about 57 percent of total Medicaid costs.[37] Were this level of cost sharing to resurface for the Medicaid expansion population years from now, it could likely be devastating to state budgets.

This consideration has led many states to request reassurance that they will have the option to withdraw from the expanded Medicaid program if they accept the federal funds now; as discussed earlier, the Obama Administration has provided such assurances at this time.[38]

Another ''requirements'' issue comes in a letter from Virginia Gov. Bob McDonnell (R), who provided President Obama with a list of some of the clarifications Republicans are seeking from the Obama Administration before making a decision whether to expand their states' current Medicaid programs.[39] One of particular significance includes the permissibility of measures that ''encourage personal responsibility—cost sharing or accountability provisions, the use of high deductible plans such as Health Savings Accounts, and other options at the state's choice.''[40] Although Gov. McDonnell did not explicitly seek block grants, other governors, such as Louisiana Gov. Bobby Jindal (R), have done so.[41] Under block grants, the federal government provides an annual lump sum to the states for a declared purpose without many federal requirements attached to the money.[42] At this stage, block grants are not an option that the Obama Administration is willing to consider.[43]

Alternatively, Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to grant Medicaid demonstration waivers. On a state-by-state basis, the HHS secretary may grant these waivers to allow states to use federal funding without adhering to all federal requirements for a purpose that ''promotes Medicaid program objectives.''[44] Several other grants have been awarded to states under new authority in the ACA for early expansion of benefits and various experimentations in the structure of federal financing.[45] Given the factors favoring expansion in reluctant states, flexibility around items such as cost sharing may make the Medicaid expansion more attractive. As previously stated, an example of a successful use of the Section 1115 waiver continues in the Arizona Health Care Containment System.[46] This demonstration waiver allowed Arizona to forego the traditional fee-for-service Medicaid model and utilize a strictly managed care system. Arizona's Section 1115 waiver began with Arizona's initial entry into the Medicaid program in 1982 and remains in place. It has served as a model for cost-savings and quality improvement.[47]

Conclusion

In light of the Court's recent ACA decision, states have the option whether to expand their current Medicaid programs to include new segments of the state's population. While there is federal funding now for most of this expansion, there is uncertainty as to whether states may rely on such federal funding in the near-term, when there is such need for deficit reduction and entitlement reform at the federal level of government. It is also an enormous challenge to terminate a government program once established, even if such termination is necessary for fiscal or other public policy reasons.

Consequently, when deciding whether to expand their Medicaid population, it is incumbent on all state government leaders and related stakeholders to consider the many factors at play in each state's individual determination including, among other aspects, the political climate, the economy, individual state processes, and the federal funding and other requirements of expansion.

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[35] ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS UPDATED FOR THE RECENT SUPREME COURT DECISION, *supra* note 24, at 18 tbl. 1(2012). The CBO reduced this number to seven million lives based on their estimate for the number of states that will decline expansion. *Id*.

[36] Kyle Cheney, *GOP Governors Not Absolute in Opposition to Medicaid Expansion*, POLITICO PRO (July 13, 2012, 12:18 PM).

[37] ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS UPDATED FOR THE RECENT SUPREME COURT DECISION, *supra* note 24, at 7.

[38] Betbeze, *supra* note 26.

[39] Letter from Bob McDonnell to President Obama (July 10, 2012), *available at* http://rgppc.com/medicaid-and-exchange-letter-2/.

[40] *Id*.

[41] Brett Norman, *Ex-CMS Chiefs Say 'Make Nice' on Medicaid*, POLITICO PRO (July 10, 2012, 2:28 PM); *see also* Kyle Cheney, *Utah, Tennessee Govs: Give Us Block Grants and We Might Expand*, POLITICO PRO (July 13, 2012 3:51 PM).

[42] Mary Agnes Carey & Marilyn Werber Serafini, *How Medicaid Block Grants Would Work*, KAISER HEALTH NEWS (Mar. 6, 2011), http://www.kaiserhealthnews.org/stories/2011/march/07/block-grants-medicaid-faq.aspx.

[43] GOP Governors Name Their Price, *supra* note 17.

[44] Samantha Artiga, *Five Key Questions and Answers About Section 1115 Medicaid Demonstration Waivers*, KAISER FAMILY FOUND. (2011), http://www.kff.org/medicaid/upload/8196.pdf.

[45] *Id*.

[46] *A Brief History of AHCCCS*, ARIZ. HEALTH CARE COST CONTAINMENT SYS. http://www.azahcccs.gov/Careers/History.aspx.

[47] *See* U.S. GEN. ACCOUNTING OFFICE, ARIZONA MEDICAID: COMPETITION AMONG MANAGED CARE PLANS LOWERS PROGRAM COSTS (1995), *available at* http://www.gao.gov/assets/230/221770.pdf.