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Dynamic Expansion

Nicole Huberfeld

DYNAMIC EXPANSION

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Nearly one in four Americans will have medical care and costs covered by the Medicaid program when it has been expanded pursuant to the Patient Protection and Affordable Care Act (the ACA). National media outlets have been reporting that only about half of the states are participating in the Medicaid expansion; if the reports were true, millions of Americans would be left without insurance coverage, and many of the nation's medically fragile citizens would not have access to consistent healthcare. Contrary to these reports, most states will participate in the Medicaid expansion in the near future. This claim is not merely predictive; data I have gathered reveals that most of the states currently counted as "not participating" are in fact taking steps toward Medicaid expansion. States' refusal to expand will create a health insurance black hole for very poor childless adults,[1] but most will not stay in the "not participating" category for long.

This Essay provides preliminary documentation and analysis of states' evolution toward expanding their Medicaid programs from May through October of 2013, the crucial time period before the key health insurance provisions of the ACA went on-line. The data is still evolving, but if the fluidity displayed during summer of 2013 is predictive, then most states will be participating in the Medicaid expansion in the not too distant future. In addition to the predictive and descriptive counter-narrative presented by the data, this Essay illuminates the dramatic, dynamic negotiations occurring between federal and state governments and within state governments. The interest in negotiation undercuts the version of federalism that the Supreme Court protected in the name of state sovereignty in *NFIB v. Sebelius*.[2] In sum, my preliminary data provides a compelling early story of federalism in action that controverts the common account.

I. Expansion

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[1] Nicole Huberfeld, Elizabeth Weeks Leonard & Kevin Outterson, *Plunging into Endless Difficulties: Medicaid and Coercion after* National Federation of Independent Business v. Sebelius, 93 B.U.L. REV. 1, 85-86 (2013) (predicting the gap in insurance coverage likely to result from the Court's holding in *NFIB*).

[2] 132 S. Ct. 2566 (2012).

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The ACA expanded Medicaid enrollment eligibility standards as part of the effort to create near-universal insurance coverage. When Congress enacted Medicaid in 1965, the program was designed to cover the "deserving poor," meaning the elderly, disabled, pregnant women, and children. The ACA ended Medicaid's limitation to the deserving poor by expanding eligibility to all adults under age sixty-five with income up to 133% of the federal poverty level.[3] The expansion population will include working poor non-parents in Medicaid for the first time. The federal government will fund the expansion totally from 2014-2017, gradually decreasing the federal match to 90% by 2020.[4] States that expand their Medicaid populations will be able to shift the cost of their uninsured and indigent patients to the federal government, thereby saving money in the long term.[5]

States that do not expand Medicaid eligibility will create a hole in coverage for the working poor below 100% of the federal poverty level but above states' very minimal, prior-existing coverage for those who earn almost no income. This population, which I have dubbed the penultimate poor, will fall into this hole because the ACA provides tax credits for people whose incomes are between 100% and 400% of the federal poverty level to purchase private insurance in the health insurance exchanges ("marketplaces"), but it does not provide tax credits to people below 100% of the federal poverty level. Current estimates are that nearly five million people will fall into this hole.[6]

The ACA does not permit partial expansion of Medicaid eligibility; nonetheless, the Department of Health and Human Services (HHS) has been open to reviewing states' proposals to expand Medicaid by alternative means. If a state intends to expand its existing Medicaid program to a new category of eligibility, it submits a State Plan Amendment to HHS. But, if a state wants to expand by unconventional means, then typically the state must seek a Section 1115 "demonstration waiver" from HHS, a more unpredictable and lengthier process.[7] HHS approved the first

[3] Pub. L. 111-148, 124 Stat. 119 (2010), § 2001(a)(1).

[4] 42 U.S.C. § 1396d(y) (2013).

[5] *See*, *e.g.*, Carter C. Price and Christine Eibner, *For States That Opt Out Of Medicaid Expansion: 3.6 Million Fewer Insured And $8.4 Billion Less In Federal Payments*, 32 HEALTH AFFAIRS 1030 (2013).

[6] Kaiser Family Foundation, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid* (Oct. 23, 2013), http://kaiserfamilyfoundation.files.wordpress.com/2013/10/8505-the-coverage-gap-uninsured-poor-adults7.pdf.

[7] State Innovation Waivers to begin in 2017, so Section 1115 waivers granted now will last three years. *See* Centers for Medicare and Medicaid Services, *Medicaid and the Affordable Care Act: Premium Assistance* (March

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Medicaid expansion section 1115 demonstration waiver for Arkansas on September 27, 2013, which gives Arkansas permission to experiment with new enrollee's coverage. Instead of placing the new population in Arkansas' existing Medicaid managed care program, new enrollees will purchase insurance on the state's exchange with the state paying the premium for private insurance.[8] That approval is likely to encourage other states to begin to engage in similar negotiations with HHS if they have not already done so.

II. Nuances of State Implementation

For purposes of studying the Medicaid expansion's incremental implementation, I used the same five categories as the national news outlets tracking state implementation. This streamlined collection of basic state implementation data and provided natural contrast. The categories were: participating; not participating; alternative model; leaning toward participating; and leaning toward not participating. For each state, I collected data regarding the political party of the governor, the political party of the legislature,[9] Medicaid expansion status, a "status narrative" (a qualitative description), health exchange status, and health exchange progress. The health exchange status was collected as a point of comparison and to determine whether Medicaid expansion correlated to state-based exchange implementation. The "status narrative" was gathered from multiple news sources but primarily relied on local newspaper reporting, which captured the intra-state politics key to states' progress toward expansion.

The data shows that the twenty-four states participating in the Medicaid expansion as of the writing of this Essay are: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Rhode Island, Vermont, Washington and

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2013), http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf.

[8] *See* Letter from Marilyn Tavenner to Andy Allison, Director of Arkansas Department of Human Services, available at http://posting.arktimes.com/media/pdf/arkansassignedapprovalltr.pdf (letter approving the Arkansas Demonstration Waiver for three years); Arkansas Section 1115 Demonstration Waiver application, available at http://op.bna.com/hl.nsf/id/bbrk-9adker/$File/ArkApplicationAug2013.pdf.

[9] State political processes vary, and each state has a different method of implementing the Medicaid Act; the data collected thus far is not fine enough to capture each state's individual political process. But, by including the political affiliation of the governor and the legislature, the influence and role of governors versus legislatures became clearer.

West Virginia (and the District of Columbia).[10] Arkansas has a waiver from CMS to expand to the newly eligible population through the exchange rather than through traditional Medicaid coverage and is the only state to have obtained a waiver for expansion. But, Iowa has submitted a similar waiver application,[11] as has Indiana.[12]

Six states have declared they will not expand their Medicaid programs and have taken steps to prevent expansion this year: Alabama, Louisiana, Mississippi, North Carolina, South Carolina, and Texas. These states' governors appear to have taken a firm stance against the ACA in its entirety, rejecting both the Medicaid expansion and health insurance exchanges. Each of these governors has publicly denounced Medicaid expansion, and they have legislative majorities that agree with that position. Efforts by minority legislators, the polity, or healthcare stakeholders to persuade these state governments to expand Medicaid have been unsuccessful. For example, Governor Perry submitted a letter to Secretary Sebelius days after *NFIB* was decided proclaiming that Texas opted out of both the Medicaid expansion and the health insurance exchanges.[13] Governor Jindal of Louisiana also publicly rejected the expansion in a letter published in the *Washington Post*, and the legislature prevented a public referendum that would have allowed the Louisiana polity to vote for the expansion.[14] Of these states, only South Carolina

[10] *See id.* at 1.

[11] *State Medicaid and CHIP Income Eligibility Standards Effective January 1, 2014*, *supra* note _, at 2 n. 10; O. Kay Henderson, *State of Iowa still waiting for waiver ruling from federal government*, RADIO IOWA (Sep. 30, 2013), http://www.radioiowa.com/2013/09/30/state-of-iowa-still-waiting-for-waiver-ruling-from-federal-government-audio/.

[12] *Id*. at 2 n. 9. When HHS approves an application for a section 1115 waiver, it gives a state permission to violate the terms of the Medicaid Act to pursue an alternate plan for its Medicaid program. Such waivers must be budget neutral. 42 U.S.C. § 1315.

[13] Letter from Governor Rick Perry to The Honorable Kathleen Sebelius, July 9, 2012, available at http://governor.state.tx.us/files/press-office/o-sebeliuskathleen201207090024.pdf (last visited Oct. 25, 2013). About one year later, the Texas legislature passed a law preventing Medicaid expansion in the state, apparently responding to HB 3791, an alternative expansion plan that responded to lobbying by health industry stakeholders. James Jeffrey, *Texas Bill Thwarts Medicaid Expansion Here*, AUSTIN BUS. J. (May 28, 2013), http://www.bizjournals.com/austin/blog/abj-at-the-capitol/2013/05/texas-bill-thwarts-medicaid-expansion.html; *see also* Texas House Bill 3791, available at http://legiscan.com/TX/bill/HB3791/2013.

[14] Bobby Jindal, *Let's Meet on Medicaid Mr. President*, WASH. POST (Jan. 28, 2013), http://www.washingtonpost.com/opinions/bobby-jindal-to-fix-medicaid-listen-to-governors/2013/01/28/ff5c8e5e-6711-11e2-85f5-a8a9228e55e7_story.html; *see also* Michelle Millhollon, *Senate bats back another effort to accept Medicaid expansion*, THE ADVOCATE (June 2, 2013), http://theadvocate.com/home/6099052-125/senate-bats-back-another-effort.

appears to have planned for the reduction in federal payments to hospitals that treat a disproportionate share of indigent patients (which the ACA set in motion in anticipation of near-universal insurance coverage) by allocating additional state funds to hospital payments.[15]

The remaining twenty states present a remarkably consistent set of developments. The most common trend among states categorized as "leaning toward not participating," somewhat counterintuitively, is that Republican governors have encouraged their states to participate in the expansion through various means including legislative influence, public announcements, special commissions, budget allocations, and informal negotiations with CMS. The Republican governors of Florida, Oklahoma, Pennsylvania, South Dakota, Tennessee, and Utah have declared their intent to expand to the newly eligible Medicaid population. Some of these governors have expressed interest in alternative formats like Arkansas's, such as Governor Mead of Wyoming, who had the state's Department of Health study and report on a premium assistance program.[16] In addition, the Democratic governors of Missouri, Montana, and New Hampshire have announced support for the expansion, but their states are classified as "leaning toward not participating" because their Republican legislatures are undecided. Virginia is likely to expand given the recent election of a Democratic governor who made the expansion a central issue.

Similarly, in states that are classified as "not participating" (other than the six named above), Republican governors have commissioned studies regarding the economic feasibility of expanding with an eye toward the 2014 budget cycle. Alaska and Idaho fit here, as does Georgia. Even though Georgia's governor publicly rejected Medicaid expansion early in 2013 and has been perceived as a hard opt-out, he signed legislation that created a "Joint Study Committee on Medicaid Reform," which will study the whole Medicaid program in the state, including the possibility

[15] Proposed actions regarding its methods and standards for establishing Medicaid Disproportionate Share Hospital (DSH), South Carolina Department of Health and Human Services (08/13/13, 10:30), https://www.scdhhs.gov/public-notice/proposed-actions-regarding-its-methods-and-standards-establishing-medicaid.

[16] Reporting indicates that the governor directed the Department of Health to conduct studies so that he would be prepared for whatever decisions the legislature made. In August, a legislative committee put forth a waiver plan that seems to be garnering support. Trevor Brown, *Optional Medicaid expansion could cost the state $58.5M*, WYO. TRIBUNE EAGLE (Sep. 7, 2013), http://www.wyomingnews.com/articles/2012/09/07/news/01top_09-07-12.txt; Trevor Brown, *State to Consider Alternative Medicaid Expansion*, WYOMING TRIBUNE EAGLE (Aug. 25, 2013), http://www.wyomingnews.com/articles/2013/08/26/news/01top_08-26-13.txt.

of expansion.[17] Wisconsin's Republican governor has expressed support for expanding the state's coverage of uninsured citizens, but he has not done so through the Medicaid program, rather through private insurance (purchased through the exchange) for people at the federal poverty level and above while rejiggering state payment for Medicaid enrollees.[18]

In a few states, the legislature is leading expansion efforts. For example, even though Governor LePage declared that Maine will not expand, the Maine legislature would have successfully overridden his veto if not for a botched override vote. The legislature will hold another vote in the next legislative session.[19] Nebraska also has a legislative coalition that proposed expansion despite the governor's opposition, and a vote may succeed in the next legislative session slated for January 2014.[20] In Kansas, both the legislature and the governor have been lobbied heavily for expansion, but they have been waiting to see if federal funding will be available as promised.[21]

As recently as May of 2013, these same five categories broke down differently. Noticeably more states were leaning toward not participating or had declared that they were not participating. For example, Alaska was listed as not participating, but it is now a state where the governor commissioned a study on expansion and will make further announcements with the next budget cycle. Arkansas was pursuing an alternative model, which has been approved. Idaho was listed as not participating, but its governor now has the state's department of health working on a plan for 2014. Iowa was listed as not participating, but it has since pursued an alternative model. Maine was described as not participating, but the legislature is poised to override the governor's opposition. New York was leaning but is now officially participating. Oklahoma was deemed not participating,

[17] *See* H.R. 107, available at http://www.legis.ga.gov/Legislation/en-US/display/20132014/HR/107.

[18] Rich Kremer, *Wisconsin Using ACA To Expand State-Run Healthcare While Declining Medicaid Expansion*, WIS. PUB. NEWS RADIO (Oct. 23, 2013), http://news.wpr.org/post/wisconsin-using-aca-expand-state-run-healthcare-while-declining-medicaid-expansion.

[19] A.J. Higgins, *Maine Democrats Plan to Introduce New Medicaid Expansion Bill*, MAINE PUB. BROAD. NETWORK (Sep. 17, 2013), http://www.mpbn.net/News/AffordableCareActandMaine/AffordableCareActNews/tabid/1606/ctl/ViewItem/mid/5706/ItemId/30031/Default.aspx.

[20] Paul Hammel, *22 Nebraska senators pledge to keep fighting for Medicaid expansion*, OMAHA.COM (June 5, 2013), http://www.omaha.com/article/20130604/NEWS/706059979.

[21] Dave Ranney, *Kansas lawmakers urged to consider Medicaid expansion*, KANSAS HEALTH INSTITUTE NEWS SERVICE (Aug. 29, 2013), http://www.khi.org/news/2013/aug/29/kansas-lawmakers-urged-consider-medicaid-expansion/.

but now the governor favors an alternative. Pennsylvania was characterized as not participating, but now the governor is leading the state to expand. South Dakota was listed as not participating, but the governor created a task force to examine the possibility of expansion. Wisconsin was deemed not participating, but now the state has executed its own expansion and may still pursue a waiver. This summary demonstrates the momentum that has been hidden in the broadly generalized and outdated reporting regarding state participation in Medicaid expansion.

III. Fluid Implementation

The Medicaid expansion is beginning to expose a fluid and vigorous federal-state, inter-branch, and intra-state set of negotiations. Studying states' decisions in order to reveal this dynamism was important for at least four reasons. First, Medicaid was not immediately implemented in all fifty states in 1965. While some states embraced Medicaid immediately, others nearly missed the 1970 deadline for participation, and Arizona and Alaska abstained for many years.[22] Second, states historically cannot resist offers of large sums of federal money, particularly when it is connected to healthcare.[23] Third, the summer of 2013 was a particularly important time frame for capturing state decision-making. Enough time had passed since *NFIB v. Sebelius* was decided to allow HHS to answer states' questions about implementation. It was also the last legislative session that would allow states to meet the ACA's effective date, but governors continue to work even when state legislators go home. Fourth, as Medicaid stakeholders learned of their states' inclinations, they imposed public pressure and monetary pressure on states to implement the expansion, which has taken time to affect the conversation between state legislatures and governors. For these and other reasons, it seemed clear to me that the states would be moving toward expanding their Medicaid programs, though perhaps more slowly than the January 1, 2014 ACA implementation date.

In addition, national media has counted inconsistently which states will participate in the Medicaid expansion. For example, Kaiser Family Foundation reports that twenty-five states (and the District of Columbia) are participating; the consulting

[22] ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA 61 (1974).

[23] *See, e.g.*, Kaiser Family Foundation, *A Historical Review of How States Have Responded to the Availability of Federal Funds for Health Coverage* (2012), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8349.pdf.

group the Advisory Board Company, which publishes the popular American Health Line map, has counted that twenty-one states are participating and that another eight states are leaning toward participating;[24] the *Washington Post* counted Ohio as the twenty-sixth state to participate in the Medicaid expansion;[25] and HHS calculates twenty-four states plus the District of Columbia as expanding.[26] These major sources, which are cited by many other media outlets, are counting participation dissimilarly. And, some of their reporting has not been updated since the late spring or early summer, thereby omitting the key months leading up to implementation. The constant citations to these incomplete studies made tracking this data even more important.

A preliminary analysis of the data to date contrasts with the public reporting in significant ways. First, states that have submitted state plan amendments or waivers to HHS are a stable and growing group. They have agreed to expand Medicaid to poor citizens historically excluded from the safety net, and many did so quickly after the enactment of the ACA, though some states have not permanently funded their expansion.[27] Also, some states have included sunset clauses in their enabling legislation that will force political reevaluation when federal funding decreases in 2017. But, the twenty-four (or more) states that have expanded by the end of 2013 will draw down complete federal funding for the three years that total funding is available. The generous funding offered for the expansion population, even when states shoulder a small portion of the cost, will encourage participating states to continue their eligibility expansion.

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[24] Advisory Board Company, *Where the States Stand on Medicaid*, http://www.advisory.com/Daily-Briefing/Resources/Primers/MedicaidMap#lightbox/2/ (last visited Oct. 23, 2013); *see also* American Health Line, *Medicaid Expansion Map*, http://www.americanhealthline.com/Analysis-and-Insight/Infographics/Medicaid-Expansion-Map (last visited Oct. 25, 2013).

[25] Sarah Kliff, *Ohio's new Medicaid expansion could cover 330,000 people*, WASH. POST (Oct. 21, 2013), http://www.washingtonpost.com/blogs/wonkblog/wp/2013/10/21/ohios-new-medicaid-expansion-could-cover-330000-people/.

[26] Centers for Medicare and Medicaid Services, *State Medicaid and CHIP Income Eligibility Standards Effective January 1, 2014*, http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf (last visited Oct. 23, 2013).

[27] For example, New Jersey funded the expansion as part of a two year budget. *See* Senate Bill No. 2644, at http://www.njleg.state.nj.us/2012/Bills/S3000/2644_I1.HTM, vetoed by Governor Chris Christie on July 29, 2013. *See* New Jersey State Legislature Bill Search, http://www.njleg.state.nj.us/bills/BillView.asp (last visited Oct. 25, 2013).

Conversely, states that have rejected the Medicaid expansion in a manner that seems immovable have not made permanent decisions. In each of those states, legislative minorities, healthcare providers, advocacy organizations, and poor citizens are decrying the political decision to opt out. The next election may precipitate reversals in opt-out states, as they have substantial numbers of uninsured adults who will fall into the coverage black hole. Texas encompasses about a quarter of the uninsured adults who will not gain Medicaid coverage because of the political decision to opt-out.[28] Florida, Georgia, and North Carolina account for another 30% of the uninsured who will not gain coverage.[29] These states' governing bodies will continue to be under pressure to expand.

In states that have not yet committed to expanding, lively intra-branch negotiations have been transpiring that clearly point to movement toward expansion. A natural query would be why Republican governors who are driving state legislatures to expand are bucking their party's wholesale rejection of the ACA. My early interpretation of this particular trend is that governors work more consistently than legislators with state Medicaid agencies and see the reach of the program for their citizens on a near-daily basis. Governors work more closely with state Medicaid commissioners, deal with the Medicaid budgets more often, and see the big picture for the state regarding shifting healthcare costs to the federal government while at the same time creating more medical sector jobs in their states. Legislators experience Medicaid as supplicants (seeking special payments for their local hospitals, seeking enrollment for citizens in their districts who may be struggling) and as budgetary watchdogs (Medicaid draws down significant federal money, but its cost is a conversation driver, especially in states with balanced budget requirements in their constitutions). It may be easier for legislators to ignore the state-wide need for Medicaid expansion than it is for governors to do so. Even when not driven by gubernatorial agenda-setting, states that are currently categorized as leaning - in either direction - are proceeding toward expansion.

One important aspect of this analysis is the trending it details – that most states currently characterized as not participating or leaning toward not participating in fact are acting to explore and to implement Medicaid expansion. HHS's tally must by its nature be limited, as without paperwork these chickens cannot be counted before they hatch. But, the local reporting reveals a changeable and changing landscape. This is a hidden

[28] *The Coverage Gap*, *supra* note 6.
[29] *See id.*

story, the ongoing negotiations between state governors and their legislatures.

Additionally, the accessibility that CMS has telegraphed, leading many states to explore alternative expansion possibilities, is a part of the hidden story. This is especially true now that Arkansas has HHS's waiver approval. Indiana and Iowa have waiver applications in the review process. Tennessee has been actively discussing its alternative plans with HHS. And, as was discussed above, other states are exploring alternative expansion mechanisms. Thus, another important aspect to this study is federal-state negotiations over alternative expansion mechanisms. These negotiations reveal a dynamic federalism that has long been present in Medicaid but that has been particularly vibrant in the last few months.[30]

Somewhat paradoxically, this analysis exposes the Supreme Court's aggrandizement of its own power to police the line of authority between the federal government and the states in the name of state sovereignty. In *NFIB v. Sebelius*, the Court cast its role as protecting states from coerced participation in the expansion of Medicaid initiated by the ACA. To so protect state sovereignty, the Court limited HHS's authority to penalize states for failure to participate in the ACA's expansion of Medicaid, effectively permitting states to opt-in or opt-out of the Medicaid expansion. To arrive at this conclusion, the Court proclaimed that the Medicaid expansion was a new program, separate and apart from existing Medicaid. I have described elsewhere why this legislative interpretation does not hold water;[31] here, I add to that analysis by observing that the Medicaid Act has always given the Secretary of HHS authority to waive state compliance with the Medicaid Act. In other words, even though Congress did not write new Medicaid waivers into the expansion provisions of the ACA, it did not need to, because states have had power to seek waivers since the Medicaid Act was passed in 1965. In fact, section 1115

[30] While the term dynamic federalism has been applied in other federal-state cooperative federalism contexts such as environmental law, it has not heretofore been commonly applied in Medicaid-related literature. *See* Kirsten H. Engel, *Harnessing the Benefits of Dynamic Federalism in Environmental Law*, 56 EMORY L.J. 159, 176-77 (2006) (describing dynamic federalism as reinforcing "values of plurality, dialogue, and redundancy"). Other theories of legislative federalism have been expressed. *See* Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 YALE L. J. 534, 588-89 (2011) (discussing five forms of federalism expressed in the ACA). Professor Gluck described Medicaid as traditional cooperative federalism and acknowledged the field claiming federalism present in the Medicaid expansion, *see id.* at 587. I discussed this at greater length in *Federalizing Medicaid*, 14 U. PA. J. OF CONST. L. 431 (2011).

[31] Huberfeld *et al*., *supra* note 1, at 73-74.

waivers were created in 1962 as an amendment to the Social Security Act.[32]

Thus, the Court did not create this seemingly new ability for states to negotiate waivers with HHS in *NFIB v. Sebelius*; it existed all along in the "old" Medicaid Act, and it is being used to implement the Medicaid expansion in the very states that are reported as rejecting the expansion. The new and undefined coercion doctrine did not need to be articulated. This dynamic execution of the Medicaid expansion will take time to fully reveal itself, but the pattern that is coming into focus is quite different from the fragile state sovereignty depicted by the Court.

Conclusion

NFIB lead to constant speculation regarding which states would exercise the ability to opt-in or opt-out of Medicaid. Fed by the high profile case, national media have been tracking the expansion through color-coded maps that tend to rely on a five category sorting. States that have been categorized as not participating, leaning toward not participating, or alternative have been in constant flux over the last several months. The majority of these states have performed or are engaging in studies, negotiations, and other processes that move them toward participating in the Medicaid expansion. Though the media have reported that only half of states are participating, of the remaining states categorized as not participating or leaning toward not participating, all but about six are actively debating and planning to expand. The future of Medicaid expansion is not nearly as bleak as the media suggests. If anything, the Medicaid expansion is beginning to expose an animated set of political choices at both the state and the federal level that feed a dynamic federalism story that has so far evaded the Court's understanding. The story of the Medicaid expansion is just beginning, and it will take time to fully develop the research I have begun to analyze here, but the preliminary enquiry indicates strong prospects for Medicaid expansion.

[32] DAVID G. SMITH & JUDITH D. MOORE, MEDICAID POLITICS AND POLICY 1965-2007 332 (2008).