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# Medicaid Expansion Costs in North Carolina: A FRANK DISCUSSION

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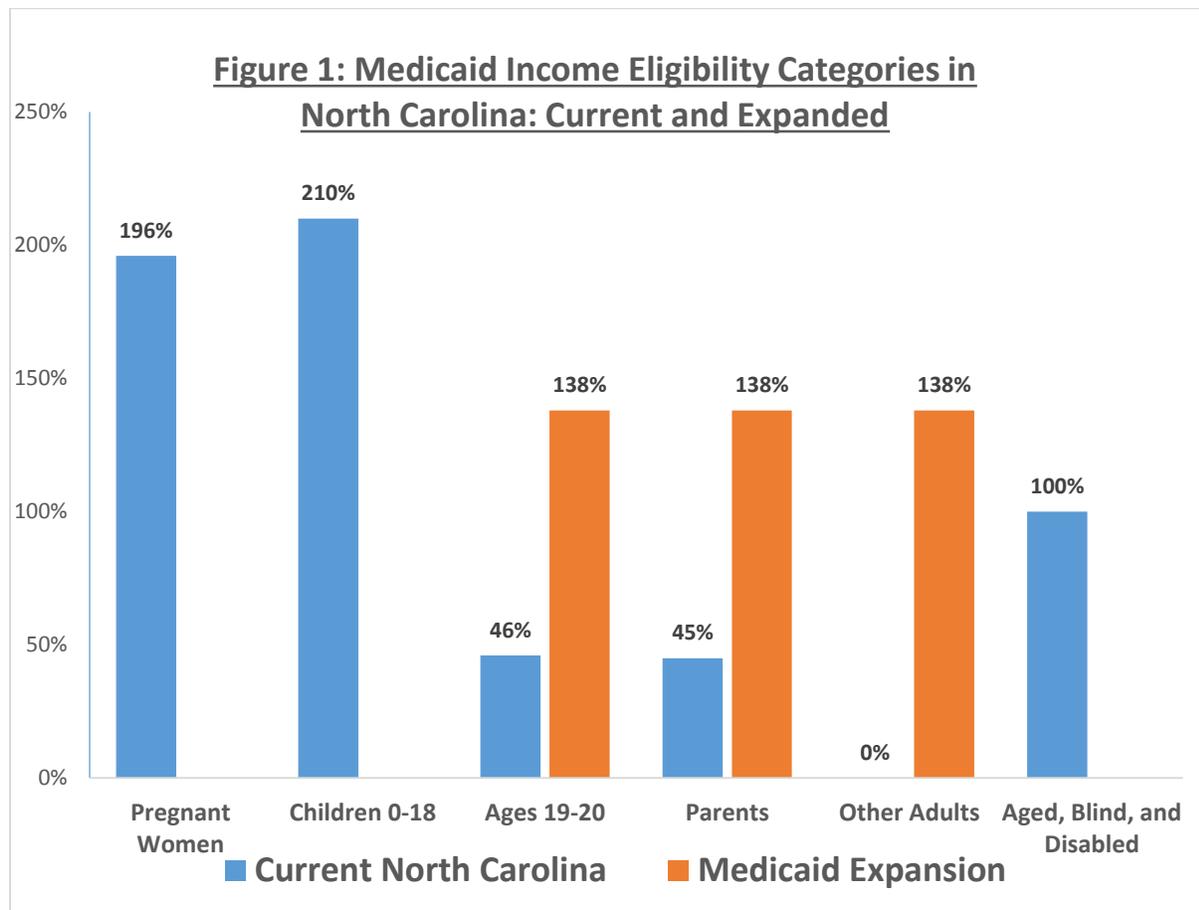
HEALTH LAW AND POLICY PROGRAM

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The history of Medicaid in North Carolina has always been contentious. It took the state five years to adopt Medicaid after the federal government first enacted the program in 1965, and it has now been five years since the Patient Protection Affordable Care Act (ACA) was enacted, allowing states to expand Medicaid. State political leaders have said that we need to overcome two major hurdles before seriously considering Medicaid expansion: Supreme Court challenges to the ACA, and reform of North Carolina’s existing Medicaid system. This past summer the Supreme Court dismissed the last remaining legal challenge to the ACA, and more recently the North Carolina legislature adopted a Medicaid reform bill that Gov. McCrory signed into law. These two developments now clear the decks for an honest dialogue about the costs and benefits of expanding Medicaid.

## 1 CURRENT AND EXPANDED MEDICAID

The Affordable Care Act provides subsidies for people to buy private health insurance if they are above poverty. Those subsidies are not available, however, for people who are poor. Instead, they must rely on the state’s Medicaid program. In North Carolina, Medicaid currently covers people below 100% of the Federal Poverty Level (FPL) if they are aged, blind, or disabled. As shown in Figure 1, parents with dependent children are covered only if they earn less than 46% of the poverty level. Coverage for pregnant women and children (including the related “CHIP” program) is more generous, going up to about twice the poverty level. But other adults—those without children and who are not disabled or elderly—are not covered by Medicaid in North Carolina, regardless of how little they earn.



Medicaid is paid for with both federal and state funds. Currently, the federal government pays for 66% of Medicaid's costs, and North Carolina pays the remaining 34%, resulting in a 2:1 federal "match."<sup>1</sup>

Medicaid expansion changes both *who* is covered, and *how much* the federal government pays for Medicaid. First, as shown in Figure 1, Medicaid expansion would cover all non-elderly adults who earn up to 38% above the federal poverty level. Currently, that amounts to \$16,243 for a single person and \$33,465 for a family of four; in comparison, current minimum wage pays a full-time worker about \$15,000 a year. North Carolina's higher coverage levels would remain for children and pregnant women; and, aged, blind, and disabled people would still only be covered up to 100% of the poverty level, because, even at higher incomes, they are also covered by Medicare, which is a separate federal program. For all other adults, expanded Medicaid would cover anyone in a household that earns below the income limits just mentioned (which are 38% above the poverty level).

Second, Medicaid expansion changes the federal matching rate. Through 2016, the federal government would pay 100% of the costs of covering this expansion population; starting in 2017, the match rate for expansion costs goes to 95% and continues to drop each year<sup>2</sup> until it reaches 90% (or 9:1) in 2020, where it remains. Thus, starting in 2020, the federal government would continue to pay for two-thirds the cost of covering people under NC's current Medicaid levels, but federal support for the expansion population would be at the higher 90 percent level, meaning that North Carolina would need to pay for 10 percent of the expansion costs.

According to the best available estimates, expanding Medicaid in North Carolina would cover an additional half million people, three-fourths (or about 375,000) of whom would otherwise be uninsured (even though the majority of them have jobs). Few people dispute that expanding coverage would be a great benefit to people who otherwise are uninsured. The main concern about expansion is its cost. Some people, for good reason, are philosophically opposed to any increased financial support from the federal government because that raises taxes for everyone.

The overall tax burden may be a good reason to oppose enactment of *new* spending programs. However, anti-tax viewpoints do not resolve questions about whether North Carolina should join or opt out of federal programs that have *already been enacted*. North Carolina residents must pay for their portion of existing federal programs like Medicaid even if the state does not accept its share of the funds, which would amount to an additional \$5 billion a year. That is roughly equivalent to what the federal government now spends in North Carolina on defense procurement contracts, and about four times more than the federal funds the state now receives for highway construction (Glied 2013).

Although declining to expand would reduce the U.S. tax burden by this amount, that reduction would be spread across the entire country, just as if the state were to decline its share of highway funds or military spending. Therefore, the tax benefit just to North Carolinians of declining Medicaid expansion is only a small fraction of total program expense (3%, based on population). Meanwhile, North Carolina taxpayers continue to pay their share (roughly 3%) of expansion costs for the 31 other states that so far have expanded Medicaid, without receiving any of the economic benefits discussed in the next section.

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<sup>1</sup> In the past, some of the state cost was borne by counties, but this ended in 2009.

<sup>2</sup> 94% in 2018, 93% in 2019.

Nevertheless, Medicaid expansion would not be cost-free to the state. Accordingly, this issue brief addresses two cost concerns: 1) what are the realistic costs to North Carolina if it expands Medicaid under the legislated level of federal matching funding; and 2) is there a serious risk that the federal government will reduce its promised funding level, thus greatly increasing costs to the state?

## 2 COSTS OF EXPANDING MEDICAID

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The costs to North Carolina of expanding Medicaid consist of the direct costs of covering more people under Medicaid, offset by any secondary financial benefits to state government that result from having fewer uninsured citizens.

### 2.1 DIRECT FINANCIAL COSTS

According to best estimates, expanding Medicaid would directly cost the state roughly \$600 million each year, starting in 2020 when the federal matching rate levels out at 90 percent (Ku 2014).<sup>3</sup> This estimate depends on two key questions: how many additional people will sign up for expanded Medicaid, and how much will their health care cost? The answers to both are subject to uncertainty, and thus the estimated costs could be noticeably greater, or lesser, than this best estimate.<sup>4</sup> However, several factors reduce that uncertainty.

Most importantly, if total Medicaid expansion costs exceed what is currently estimated, the state is required to pay only 10 percent of that excess. Expansion opponents worry, however, that the federal government cannot be trusted to stick to its promised funding level. We address that concern in a later section. If it does not materialize, then it is important to realize that the 9:1 federal match rate promised by current law provides a tremendous financial buffer. Accordingly, recent evidence shows that states that expanded Medicaid saw overall cost increases of just 3.4% in 2015, compared with a yearly increase of twice that amount (6.9%) among states that did not expand. This impressive difference is due to the fact that federal government paid for all the increases borne by these states' expansion population, which buffered the impact of overall cost increases.

In addition, North Carolina's recent reforms to Medicaid will help to control its costs and make them more predictable. The law signed by Gov. McCrory in late 2015 will convert the state's Medicaid program to a "managed care" system that contracts with competing private entities at fixed rates per person. These "capitation" rates make costs more predictable within a given budget year, and they create strong incentives to control cost increases from year to year.

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<sup>3</sup> This estimate includes both the costs for those who are newly eligible, and also for those who are currently eligible and would newly enroll based on increased visibility of the program (the so-called "woodwork effect").

<sup>4</sup> Factors that might increase these estimates are: what proportion of newly eligible people actually enroll; and whether newly enrolled people cost more or less than people currently enrolled. Despite initial uncertainty about these factors, that uncertainty should reduce greatly after a few years under an expanded program. After a few years, maximum enrollment saturation will probably be reached. Also, "pent up demand" for postponed care by people who previously were uninsured will be largely satisfied after a year or two. And, capitation rates with private managed care organizations can be set more accurately after a couple of years of experience with actual medical costs. It is for these reasons that, although people initially enrolled under Medicaid expansion in other states cost 19 percent more than current adult Medicaid recipients, federal actuaries predict that, in future years, newly-eligible people will cost less than those who are currently enrolled (US DHHS 2014). In 2014, states that have expanded Medicaid, on average, spent 38% less on newly eligible people than on their existing Medicaid enrollees (Snyder 2016).

Despite these improvements, Medicaid expansion undoubtedly will impose some considerable cost on the state. Even at 10 cents on the dollar, some people worry that the state simply cannot afford to expand Medicaid, or that doing so will draw state funding away from other needs that are more compelling. This concern is reduced, however, by noting ways in which Medicaid expansion could bring other, secondary financial benefits to the state.

## **2.2 SECONDARY FINANCIAL BENEFITS**

Independent, nonpartisan experts, backed by recent experience, predict that expanding Medicaid will produce the following financial benefits to the state, that offset the direct financial costs: 1) job creation and economic stimulus that generates more tax revenue; 2) reducing costs for treating people without insurance; and 3) reducing costs of other state programs that currently serve the people who will be covered by Medicaid expansion. We describe the evidence that supports each of these predictions.

*Job Creation and Economic Stimulus.* Because of the 9:1 federal matching rate, every dollar the state spends on Medicaid expansion will bring in nine dollars of federal funding. This “multiplier effect” creates a strong economic stimulus that creates jobs and generates more spending. This stimulus in turn leads to increased tax revenues for the state that help to pay for Medicaid expansion and other social benefits and government costs. This economic improvement could also reduce social needs or budget deficits and thus help to reduce overall tax rates. This is why the state currently spends roughly \$1-2 billion a year for incentives to attract and expand new businesses (Dorn 2014; Glied 2013).

Economists have developed reliable ways to project job creation and economic stimulus that result from other sources of federal funding, such as funding for military bases. Using these techniques, various independent, nonpartisan experts have estimated that Medicaid expansion in North Carolina would generate anywhere from 20,000 to 40,000 new jobs,<sup>5</sup> or more.<sup>6</sup> Roughly half of these jobs would be in the health care sector, and the other half would be in elsewhere, such as construction, retail, service, government, etc., since the funds directed to health care help to fuel more broad-based economic growth. Health care jobs are especially valued by communities because most pay substantially higher than minimum wage and many are professional-level (“white collar”). In North Carolina, salaries averaged about \$25,000 for health care support positions in 2014, and over \$70,000 for health care professionals and technicians.

Job creation is not merely wishful thinking. Another state considering expansion, Missouri, compared the growth of health care jobs in five similar states with expansion and five without, and found that expansion states had three times the growth rate in health care jobs as those without expansion during the first half of 2014 (Mahan 2014). In Kentucky, the accounting firm

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<sup>5</sup> Using various assumptions and analysis techniques, the Council of Economic Advisors 2014 estimates that Medicaid expansion would create 19,400 jobs in North Carolina, Nystrom 2013 estimates 23,000 jobs, and Ku 2014 estimates 43,000.

<sup>6</sup> A recent study showed that for every 1% growth in a state’s insured population, there was a corresponding .38% growth in that state’s health care job market (Roehrig 2015). As noted in text, a roughly equal increase in non-healthcare jobs can also be expected. If so, this estimate would extrapolate to roughly 80,000 new jobs from Medicaid expansion. Yet another study supports an even higher estimate. These academic economists estimated that, during the recent recession, each \$100,000 in additional Medicaid spending generated 3.8 jobs (Chodorow-Reich 2012). If that ratio held true in the future, then Medicaid expansion in North Carolina could create roughly 200,000 new jobs if economic conditions (a recession) were similar. However, job creations would likely be less in a healthier economy.

Deloitte (2014) found that the decision to expand Medicaid created twice the number of new jobs than had been projected. Based on that experience, Deloitte estimated that expansion would eventually generate 41,000 new jobs in a state smaller than North Carolina.

New jobs stimulate the economy in ways that increase tax revenues due to earning more income and thus purchasing more goods and services. Increased tax collections occur even without increasing tax *rates*, simply by applying current tax rates to increased earnings and sales that result from new jobs and new spending. Accordingly, analysts at George Washington University estimated that increased Medicaid funds from expansion would generate a sufficient economic stimulus to produce an additional \$266 million a year in state and county taxes by 2020 (Ku 2014). Focusing only on state taxes, and using more conservative estimates, a firm that specializes in economic modeling for a wide variety of government programs for the North Carolina General Assembly (and other states) estimated that Medicaid expansion in North Carolina would generate roughly \$70 million of increased state tax revenue each year (Nystrom 2013).

*Reduced costs for uncompensated care.* People without insurance do not go entirely without care. Instead, they receive free or highly subsidized treatment from hospitals, community clinics, and volunteer physicians. Expansion of insurance coverage under the Affordable Care Act has noticeably reduced these costs for “uncompensated care,” and that reduction has been substantially greater in states that have expanded Medicaid (Bachrach, June 2015).

Reduced uncompensated care benefits not only the hospitals and doctors that provide this care, but also patients and employers because less of their private insurance premiums go toward defraying the losses that hospitals and doctors incur in treating patients without insurance. State and local governments absorb a modest portion of these uncompensated care costs through the hospitals and medical schools they own (in Raleigh, Chapel Hill, and Greenville), and through the health insurance they purchase for government employees.

Using conservative assumptions, the best available analysis estimated that Medicaid expansion would save state government \$60 million a year in 2020 through the portion of reductions in uncompensated care costs paid for by government-owned hospitals (Ku 2014).<sup>7</sup>

*Reduced Costs to Other Government Programs.* The people who would be covered by an expanded Medicaid are partially served by other programs the state currently pays for; therefore, expansion will reduce some of these existing state costs outside of Medicaid. For instance, enrolling people in Medicaid will reduce how much state and county governments need to spend on mental health and substance abuse treatment, and on treating people who are incarcerated.

Also, within Medicaid, expansion will reduce the state portion of costs for people who previously would have enrolled under an existing coverage category, but can instead enroll under an expansion category.<sup>8</sup> Moreover, the state’s Medicaid program currently pays for specialized

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<sup>7</sup> Not included in this estimate are savings to insurance premiums for government employees, or savings to physicians at state medical schools.

<sup>8</sup> For instance, under current Medicaid, the state pays a third of the costs for women who enroll in Medicaid when they become pregnant, but under Medicaid expansion, the state would pay only 10 percent of the costs for women already enrolled in Medicaid when they become pregnant. Similarly, when people apply for disability, there is a financial benefit to the state during the several-month time period that it typically takes to resolve a disability application. For people whose application is approved, Medicaid currently covers their health care during the application time period at the two-thirds federal match rate. Under expansion, the federal match will

limited services such as family planning and breast cancer treatment for women who currently are not fully enrolled, but would become eligible for full benefits under Medicaid expansion. For these various categories of current Medicaid benefits, the state's share of the cost would drop by two thirds (from 34 percent to 10 percent) for recipients who become eligible for expanded Medicaid.

These secondary benefits have been documented in every state where these issues have been studied (Rudowitz 2015; Bachrach, Apr. 2015). However, the size of savings is difficult to estimate with precision. Health policy experts at George Washington University (Ku 2014) estimated that Medicaid expansion would reduce current state and local spending on mental health and substance abuse treatment by \$230 million a year, but this study did not include estimates for the other components of state and local savings outlined immediately above.

Those estimates can be gauged, however, from the actual experience in other, similar, states that have expanded. Kentucky serves as one good case in point.<sup>9</sup> It is a state roughly half the size of North Carolina whose Medicaid coverage prior to expansion was broadly similar to North Carolina's. Based on its first year of experience under expansion, the consulting firm Deloitte estimated that, by 2020, Kentucky will receive financial benefits from the various sources discussed in this section amounting to \$363 million a year. Although Kentucky's existing programs differ somewhat from North Carolina's, this favorable experience bodes well for North Carolina – a larger state and therefore one that stands to benefit even more.

### **2.3 COMPARING COSTS WITH FINANCIAL BENEFITS**

Many people strongly believe that Medicaid expansion is socially and morally compelling, regardless of the costs to the state, because of the obvious benefits this provides to sick and injured people in need of care. But, here, we do not consider the health benefits of expansion. Instead, we focus only on the financial costs and benefits to the state government, as described above and summarized in Figure 2 below.<sup>10</sup>

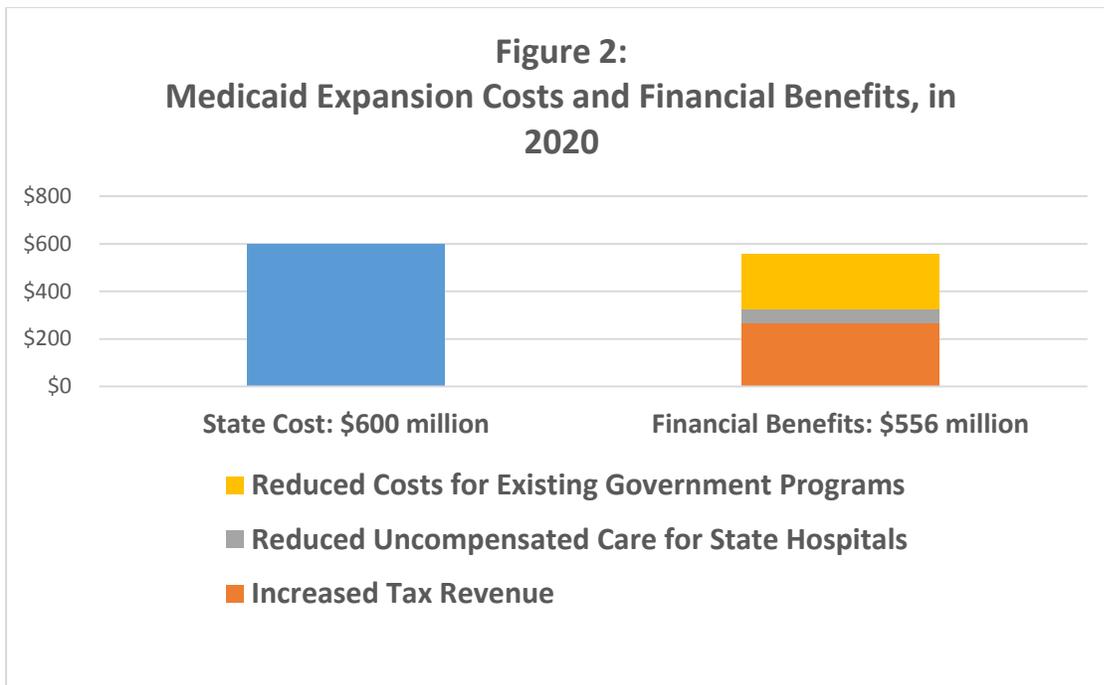
Undoubtedly, expanding Medicaid will incur some substantial cost to the state once its cost-sharing portion increases to 10 percent in 2020. However, based on expert economic forecasting and actual experience in other states, it appears that most or all of these direct state costs will be offset by financial benefits.

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increase to 90 percent for this application time period. The same is true for people currently covered by North Carolina's transitional assistance program, which continues Medicaid coverage for four months for parents whose income increases above the current 45% of poverty level (Bachrach, Apr. 2015; Dorn 2015).

<sup>9</sup> In addition, Arkansas government officials estimated that Medicaid expansion saved about \$40 million in state spending on people who were previously eligible (Bachrach, Apr. 2015). In Kentucky, the estimate was about \$20 million (Deloitte 2014), and in Washington State, more than \$100 million (Dorn 2015). Kentucky also estimated that it saved \$11 million in medical care for prisoners.

<sup>10</sup> These economic benefits mentioned are purely from the perspective of the state government and do not fully reflect the private economic benefits that the people and corporations of North Carolina would receive from expansion. Also, estimates are lacking for some categories of financial benefits to the state, so full benefits to the state may be greater than shown in Figure 2.



Health policy analysts at George Washington estimated that, starting in 2020 (when the federal match rate drops to 90 percent), Medicaid expansion would cost the state slightly more than it saves or gains, but the difference is close enough that it falls within a reasonable “margin of error.” Also, that study did not include all of the financial benefits outlined above; it omitted county tax increases, savings to existing Medicaid programs, and prisoner medical care.

The economic impacts of Medicaid expansion have been analyzed comprehensively in a total of 16 states. Each of these studies have found that, prior to 2020, expansion on balance will save rather than cost the state money, and that starting in 2020 (when the federal match drops to 90 percent), financial benefits to state governments will be approximately equal to their costs (Dorn 2014). In other words, every comprehensive financial analysis that has been done has concluded that expansion will not cost the state any substantial amount.

Because North Carolina taxpayers are already paying for most of the costs of Medicaid expansion (through federal taxes), the balance of financial costs and benefits to the state provides a strong argument for the state to fully participate in Medicaid expansion so that its citizens do not miss out on the advantages they are paying for other states to receive. That argument depends, however, on believing that the federal government will hold to its promise to pay 90 percent of Medicaid expansion costs. If it does not, then costs to the state could increase substantially. Therefore, in the final section, we consider the weight of this additional concern.

### 3 CAN WE TRUST THE FEDERAL GOVERNMENT?

Simply put, some people do not trust the federal government. If in fact it cannot be trusted, then cost projections based on the 9:1 (90 percent) match cannot be relied on, even though enacted by Congress, signed by the President, and upheld by the Supreme Court. Generalized or philosophical distrust cannot be addressed as concretely as the technical questions above about cost. However, there are three fairly concrete sub-issues that we can address when considering an attitude of distrust.

The first trust issue is whether the ACA will be defunded by Congress, or done away with by a future President. The second trust issue is whether the federal government will reduce its support for Medicaid expansion in the future. And the third trust issue is whether there are strategies North Carolina can use to mitigate the perceived risk in trusting the federal government or to respond should these suspicions be realized.

### 3.1 POLITICAL TRUST

First, can we trust the federal government to keep the ACA in place and fully funded? It is entirely possible that our next President will be both willing and able to dismantle the ACA. However, what is possible is not necessarily likely. It is one thing to oppose the ACA and its programs; it is another thing entirely to actually undo it once it is in place. Completely excising the ACA would involve rescinding insurance coverage from millions, and throwing the insurance market into shock. Short of total repeal, a Republican president could substantially rework the ACA, with uncertain implications for Medicaid expansion. However, now that well over half the states have adopted Medicaid expansion, it seems unlikely that a new administration would completely roll back expansion, especially considering that, of the 31 states to expand so far, 10 are led by Republican governors and legislatures.

The survival of the overall Medicaid program supports this perspective. When President Lyndon Johnson first signed Medicaid into law in 1965, the program was deeply unpopular in some political sectors. To this day, Medicaid is opposed by fiscal conservatives who see it as a drain on our economy and an infringement on states' rights. However, despite all the negative attention it has gotten since its inception, Medicaid has not only survived, it has greatly expanded. The modern Medicaid program, even before the ACA, is much larger than it was in 1965, and both liberal and conservative lawmakers keep funding it. This broad-based core of support suggests that, despite the unpopularity of the ACA, eliminating its Medicaid component would be unlikely.

### 3.2 FINANCIAL TRUST

Granted that Medicaid expansion is likely to survive, some people still worry that the federal government cannot be trusted to maintain the elevated 90 percent match rate that makes Medicaid expansion so financially attractive to states. Florida is sometimes cited as a recent example of the federal government reducing Medicaid support for a state. However, that is not what actually happened in Florida, for reasons explained in the sidebar bar. Nevertheless, skeptics wonder whether the federal government can afford to continue this generosity indefinitely, and what it might do to cut federal costs during financial hard times.

The federal government would have relatively little to gain from the political and public policy firestorm that would result from reducing its match rate for Medicaid expansion. Although expansion costs are substantial, the enhanced match rate accounts for only 7 percent of the federal government's overall Medicaid budget. Therefore, if Congress needs to reduce Medicaid expenses, it has a great deal more to gain by cutting other, less visible parts than the Medicaid expansion match rate. Indeed, historically, in the dozen times that the federal government has cut the Medicaid budget since 1980, it has reduced match rates only once, and then only temporarily during a recession. More commonly during recessions (such as those in 2003 and 2009), the federal government has *increased* rather than reduced its Medicaid support to states, in order to alleviate state budget deficits (Dorn 2014)

## The Florida Controversy

Medicaid expansion became controversial in Florida when its Governor, Rick Scott, said that the federal government was trying to use existing Medicaid funding to force the state to expand. This side-bar explains what happened there. Under a “waiver” of normal Medicaid rules, Florida for many years has operated a special program that allows the state to use federal funds to support a “Low Income Pool” that reimburses hospitals for a portion of their uncompensated care to uninsured patients. The federal waiver for Florida’s program was usually renewed for three years at a time. According to official documents, in February 2015 the federal agency in charge stated that it would not renew permission for this program in its present form. A few months later, the federal agency suggested that combining Medicaid expansion with the waiver program might cure its deficiencies, and the agency noted that the same might be true for existing Medicaid waiver programs in other states. Florida’s Governor accused the federal government of being untrustworthy for threatening to cancel this existing funding unless Florida expanded. Subsequently, even without Florida expanding Medicaid, the federal agency reinstated funding for Florida’s low-income pool, but with some changes agreed to by Florida.

The accusation that the federal government threatened to hold Florida’s existing funding “hostage” until Florida expanded Medicaid does not accurately portray what happened. According to credible observers and available documents, the federal agency did not threaten to renege on an existing commitment. Instead, Florida’s program had been experiencing compliance issues since 2012, and the agency previously had made it clear to Florida in 2014 that they needed to change the program in order to continue federal funding. Introducing the idea of retaining the funding contingent on expanding Medicaid might have appeared as a strong-arm tactic, but the idea was one that the state’s own study commission had identified as a way to satisfy federal requirements that had been previously established. Florida almost lost its previous funding because it did not change its waiver program when asked to do so. Medicaid waiver programs are fundamentally different from basic Medicaid expansion. Waivers are a discretionary use of federal funds by a state to test innovative approaches to providing or paying for health care; they are governed by renewable contracts that both parties must negotiate. Thus, the federal agency did not threaten to rescind Florida’s funding in the middle of the waiver period. Florida had ample warning that they needed to change their program in order to renew it. The federal government did just exactly what they said they would do under the rules, which is the basis of trust.

### 3.3 PROTECTIVE MEASURES

Federal repeal or defunding is still theoretically possible, however, so what recourse would North Carolina have should it choose to expand and the worst came to pass?

The most obvious recourse would simply be to repeal Medicaid expansion. Although rolling back Medicaid expansion might be politically unpopular, this is something that, prior to the ACA, several other states (Arizona and Tennessee for example) have done when they discovered they could no longer afford to fund previous expansions. According to one count, for instance, over the 2002–2005 period “a total of 38 states made restrictions or reductions to Medicaid eligibility in at least one of those four years.”<sup>11</sup>

North Carolina has a history of legislative self-determination when it comes to how our Medicaid program is run and where the money goes. For example, North Carolina covers certain classes of children and pregnant women more than required. Federal law only requires North Carolina to cover children and pregnant women up to 133% of the FPL, but North Carolina covers children up to 210% of the FPL, and pregnant women up to 196%. Even though these are increases of Medicaid, or expansions if you will, rather than retractions, they highlight that North Carolina has worked within these optional Medicaid spaces before despite the financial risk.

Nevertheless, future lawmakers might lack the political fortitude to retract funding if that becomes financially necessary. Therefore, one clear safeguard that current lawmakers could easily adopt would be to do what several other expanding states have done: include a “trigger provision” in the enacting legislation that cancels expansion if the federal match rate drops lower than 90 percent. An automatic statutory-repeal trigger would serve as a strong deterrent to the federal government attempting to whittle away its matching expense in order to meet future budgetary pressures. This would also provide a firm safeguard against the state having to ever pay more than its projected share of expansion expenses.

Another option would be to build a “sunset” provision into North Carolina’s Medicaid expansion statute. A sunset provision could set an event, or a fixed point in time, when the legislature must re-approve the expansion to keep it in effect. One example of this can be found in Arkansas, whose Medicaid expansion included a provision requiring the legislature to vote on continuation once the federal match rate begins to decline from 100%, in 2017 as scheduled. If the Arkansas legislature does not reapprove expansion, then its participation in expansion will cease.

Another protective measure would be to undertake expansion as part of a “waiver” agreement with the federal government, as several other states have done. A waiver not only would give the state more flexibility in how it constructs an expansion program and spends federal expansion money; a waiver agreement would also allow the state to terminate its expansion less overtly. Termination could occur during the course of negotiating a waiver renewal, simply by not seeking (or agreeing to the terms of) a continuation when the old waiver is set to expire.

In addition to a history of using, or not using, optional Medicaid provisions, North Carolina also has a history of choosing exactly where it uses its Medicaid funds. It may choose to limit administrative costs, or what extra programs get funding. As a case in point, the entire provider

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<sup>11</sup> Vernon Smith et al., Kaiser Comm’n on Medicaid & the Uninsured, *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005*, at 26 (2004), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/the-continuing-medicaid-budget-challenge-state-medicaid-spending-growth-and-cost-containment-in-fiscal-years-2004-and-2005-results-from-a-50-state-survey.pdf>.

system for Medicaid in North Carolina was overhauled this summer with a move to managed care and “provider-led entities.” In most cases these moves are made to contain cost costs, and in some cases funding has been removed from optional programs to attempt something new. The point being, if North Carolina chooses to participate in Medicaid expansion, it will not be ceding control over its own money or Medicaid program. If it chooses to expand Medicaid, North Carolina will remain the master of its own destiny, and if the federal government breaks its trust, or does something unacceptable, North Carolina remains free to leave.

## 4 CONCLUSION

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There is no denying that Medicaid expansion in North Carolina will have some costs. And, for those who distrust the federal government with a fiery passion, there may be nothing that can convince them to consider this major expansion of federal support. However, a more dispassionate examination of the issues greatly reduces well-founded concerns over expansion costs to the state.

Several expert studies have calculated what actual expansion costs would be, and what portion of those costs the state would actually bear. Expansion funding, like an iceberg, has both a visible tip, and a much larger hidden part below the surface. The tip of expansion costs, which are several billion dollars a year, is the 10 percent that the state would have to pay. The federal government pays the rest. That much larger, 90%-hidden part of the iceberg represents not a *cost* to the state, but instead money coming *into* the state.

This new federal funding melts throughout the state’s economy. The increased federal funds would create new well-paying jobs and boost economic activities that increase tax revenue without increasing tax rates. Expansion would also create savings for the state by reducing what it has to spend both on existing Medicaid recipients, and on other non-Medicaid programs like mental and substance abuse treatments and medical care for inmates. And, federal funds reduce what state and local governments currently pay for free care that now goes to low-income people who lack insurance. All told, these economic benefits and savings to state and local governments will approximately equal the extra costs to the state of expansion.

That math works as long as the federal government does not reduce what it will pay for North Carolina residents on Medicaid. Although the ACA has survived every one of the legal and political challenges it has faced, there is no guarantee that federal support will continue forever. However, it would be both illogical and extremely difficult for the federal government to back out of its deal with the states now. Even if some risk remains, states are not defenseless; they can take several steps to protect themselves, in the form of triggers, sunsets, or waivers.

The question, then, for the people and the leaders of North Carolina, is whether a small cost and a small risk are prices worth paying to provide insurance coverage to several hundred thousand people who cannot afford coverage on their own, even though the majority of them are working.

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