ANNALS OF HEALTH LAW
Advance Directive

VOLUME 22 FALL 2012 PAGES 45-59

Why States Will Likely "Opt Into" the Medicaid Expansion

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I. INTRODUCTION

The Patient Protection and Affordable Care Act (PPACA) depends heavily on Medicaid to reach the goal of near-universal health care. States' decisions as to whether or not to expand Medicaid will be an important step toward reaching universal health care nationwide. There are 11.5 million uninsured people in the United States with incomes below the poverty line that would be newly eligible for Medicaid under the expansion that would be at risk for remaining uninsured if their states do not expand Medicare.[1] Although Medicaid expansion is not the only step toward reaching universal coverage, it is a significant and vital step in the process.

On June 28, 2012, in *National Federation of Independent Business v. Sebelius*, the United States Supreme Court held that the expansion of Medicaid under the PPACA exceeded Congress's power under the Spending Clause.[2] Specifically, the Court found the statutory provision allowing the Secretary of Health and Human Services (HHS) to penalize states that choose not to participate in the PPACA's expansion of Medicaid by withholding all further federal funding for Medicaid to be unconstitutionally coercive. The Court's decision made the Medicaid

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1. Genevieve M. Kenney et al., *Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults Would not be Eligible for Medicaid?*, THE URBAN INST., 1 (2012), *available at* http:// www. urban.org/UploadedPDF/412605-Supreme-Court-Decision-on-the-Affordable-Care-Act.pdf.

2. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 U.S. 2566, 2607 (2012).

expansion now optional for states. After the decision, some state officials vowed to not participate in the Medicaid expansion when it goes into effect in 2014.[3] However, the Medicaid expansion will provide sources of savings for state governments, and "opting out" of the Medicaid expansion will likely have a negative financial consequence on states. Therefore, states may ultimately decide to opt into the Medicaid expansion.

Section II of this article will address the decision states must make regarding whether to expand Medicaid following the Supreme Court decision. Section III will examine the states' strongest arguments against the expansion. Finally, Section V of this article will examine reasons for which states are likely to accept the expansion: the financial benefits are ultimately too attractive and certainly outweigh many financial consequences.

II. U.S. SUPREME COURT'S EXPANSION OF MEDICAID WITH THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Medicaid is a joint federal–state entitlement program funded both by the federal and state governments, but is administered by the states. Since the program began, the federal government and states share the financial responsibility for providing care to beneficiaries through a matching rate system.[4] In 2009, the program accounted for twenty-one percent of state spending nationwide, with the federal government paying roughly sixty percent of the bill.[5] Excluding federal dollars, Medicaid consumes twelve

3. *See generally* THE ADVISORY BD. CO., WHERE EACH STATE STANDS ON ACA'S MEDICAID EXPANSION A ROUNDUP OF WHAT STATE'S LEADERSHIP HAS SAID ABOUT THEIR MEDICAID PLANS, http://www.advisory.com/Daily-Briefing/2012/07/05/Where-each-state-stands-of-the-Medicaid-expansion (last visited December 22, 2012).

4. Martha Heberlein et al., *Financing New Medicaid Coverage Under Health Reform:The Role of the Federal Government and States*, KAISER COMM'N ON MEDICAID AND THE UNINSURED 1, 1 (2010), *available at* http://www.kff.org/healthreform/upload/8072.pdf.

5. Benjamin D. Sommers, *Why States Are So Miffed About Medicaid- Economics*,

percent of state-generated revenues – an amount that is typically second to a state's cost of education.[6]

Under the PPACA, participating states are required to extend Medicaid eligibility by January 1, 2014.[7] Eligibility would be extended to nearly all individuals under age sixty-five with incomes up to and including 133% of the federal poverty level (FPL) (or 138% after applying a standard five percent "income disregard").[8] For those newly eligible, the federal government will pay 100% of the costs from 2014 to 2016.[9] The federal contribution will then phase down to ninety percent by 2020, where it will remain.[10]

In *Sebelius*, the Court held that the individual mandate, one of the most controversial aspects of the law, was valid under Congress' taxing power.[11] Additionally, the Court found that the PPACA cannot force states to expand Medicaid coverage to uninsured citizens by withholding current federal Medicaid funding.[12] Although the federal government may offer generous financial incentives to the states for the expansion, including full federal funding for the first three years, the Court found that the real incentive for states to participate in the expansion was the threat that a noncompliant state would lose all federal funding for Medicaid.[13] The Court found the threat to withhold current federal Medicaid funding to be coercive and

Politics, and the "Woodwork Effect," 365 NEW ENG. J. MED. 100 (2011), *available at* http://www.nejm.org/doi/full/10.1056/NEJMp1104948.

6. *Id.*

7. Randall R. Bovbjerg et al., *State Budgets Under Fed. Health Reform: The Extent and Causes of Variations in Estimated Impacts*, KAISER COMM'N ON MEDICAID AND THE UNINSURED ii (2011), *available at* http://www.kff.org/healthreform/upload/8149_ES.pdf.

8. *Id.*

9. *Id.*

10. *Id.*

11. *Sebelius*, 132 U.S. at 2608.

12. *Id.* at 2607.

13. *Id.*

unconstitutional. As a result of the decision, there is no obligation for states to expand Medicaid coverage under the PPACA.[14] Instead, states may decide to "opt out" and refuse the additional federal funds for the expansion, and they may do so without losing any current Medicaid funding.

Additionally, citizens without access to other coverage and with incomes between 133 and 400% of the FPL can qualify for new federal subsidies to buy private coverage through an Exchange.[15] Exchanges, in addition to Medicaid expansion, are another major step toward achieving universal health coverage. States are required to set up a state-based Exchange, but if they do not, the federal government will operate an Exchange for their citizens.[16] States can elect to build a fully state-based exchange, enter into a state-federal partnership exchange, or default into a federally-facilitated exchange.[17]

III. STATES' APPREHENSION TO EXPANDING MEDICAID

Immediately after the Supreme Court's ruling in *Sebelius*, some Republican state officials said they were inclined to reject the Medicaid expansion.[18] If a state decides not to implement the expansion, some of the people who would have received Medicaid could instead receive tax credits

14. Joseph Antos, *The Medicaid Expansion Is Not Such a Good Deal for States or the Poor*, 38 J. OF HEALTH POL., POL'Y & L. 179, 179 (2012), *available at* http://jhppl.dukejournals.org/content/early/2012/10/09/03616878-1898848.full.pdf.

15. *Id.*

16. *Id.*

17. *Establishing Health Insurance Exchanges: An Overview of State Efforts*, KAISER COMM'N ON MEDICAID AND THE UNINSURED 1 (2012), *available at* http://www.kff.org/healthreform/upload/8213-2.pdf.

18. Charles Ornstein, *Mystery After the Health Care Ruling: Which States Will Refuse Medicaid Expansion?* PROPUBLICA (June 28, 2012), http://www.propublica.org/article/mystery-after-the-health-care-ruling-which-states-will-refuse-medicaid-expa.

and other subsidies from the federal government.[19]

A. Budget Concerns

Some state officials have stated budget concerns as the top reason for hesitating to expand Medicaid. Many state officials are already struggling to pay for the entitlement program, which typically is the largest or second largest state expense.[20] Further, the Congressional Budget Office projects that states would pay approximately seventy-three billion, or seven percent of the cost of the Medicaid expansion between 2014 and 2022, whereas the federal government would pay $931 billion, or ninety-three percent.[21] These states argue that although their future share of the cost may sound small in comparison to the federal government's cost, it will still be a significant expenditure. Although states would pay for a small percentage of the expansion, this amount still represents billions in new spending that could require cutbacks of other more popular programs, such as education or transportation, or else raise taxes.[22] Furthermore, many state officials worry that a future, deficit-focused Congress will scale back the federal share and shift more costs of the program to the states as it seeks ways to reduce the federal budget deficit.[23]

Additionally, states are concerned with what may happen during an economic downturn, as Medicaid is designed to be "counter-cyclical."[24] States face increasing enrollment and Medicaid expense at a time when they

19. Kenney et al., *supra* note 1.

20. Phil Galewitz, *States Balk at Expanding Medicaid*, KAISER HEALTH NEWS (July 2, 2012), www.kaiserhealthnews.org/stories/2012/july/02/state-costs-medicaid-expansion.aspx.

21. *Id.*

22. *Id.*

23. Robert Pear, *Uncertainty Over States and Medicaid Expansion*, N.Y. TIMES, June 28, 2012, *available at* http://www.nytimes.com/2012/06/29/us/uncertainty-over-whether-states-will-choose-to-expand-medicaid.html?_r=0.

24. Sommers, *supra* note 5.

have decreasing revenues.[25] This occurs because when the economy is poor, more people cannot afford insurance and have incomes low enough to make them eligible for benefits.[26] Whenever there are many newly unemployed individuals because of economic downturns, the ranks of those newly eligible for Medicaid surge as well.[27] Thus, a recession doubles the havoc on states: reduced tax revenue and increased Medicaid spending.[28] Therefore, states confront fundamental challenges to their budgetary stability.

B. The "Woodwork Effect"

Many state leaders have said they worry about the "woodwork effect" from the Medicaid expansion.[29] The woodwork effect is used to describe a possible phenomenon that will occur with people who are already eligible for Medicaid under current law but are not enrolled. State officials are worried that when the Medicaid expansion goes into effect in 2014, the law will bring out of the woodwork millions of people who are already eligible for Medicaid but are not already enrolled.[30] Whereas federal funds cover 100% of costs for newly eligible individuals starting in 2014, states will continue to receive the current, traditional federal contribution rate for any additional enrollment of people who were already eligible.[31] Currently, the federal government covers between fifty to seventy-six percent of the cost

25. *Id.*
26. *Id.*
27. *See generally* Shefali S. Kulkarni, *Puzzling Out How to Help States With Hard-Hit Medicaid Budgets*, KAISER HEALTH NEWS BLOG (November 8, 2011, 4:46 PM), http://capsules.kaiserhealthnews.org/index.php/2011/11/puzzling-out-how-to-help-states-with-hard-hit-medicaid-budgets.
28. Sommers, *supra* note 5.
29. *Will Medicaid Bring The Uninsured Out Of The Woodwork?*, NAT'L PUB. RADIO (July 11, 2012) (*available at* http://m.npr.org/news/U.S./156568678).
30. *Id.*
31. Sommers, *supra* note 5.

of care, with each state's "matching rate" (or "federal medical assistance percentage" (FMAP)) depending on the state's per capita income.[32] Therefore, these "woodwork" beneficiaries will not be federally funded as newly eligible beneficiaries, but rather as current Medicaid enrollees.

According to Benjamin D. Sommers, M.D. with the New England Journal of Medicine, "millions of low-income Americans are currently eligible for Medicaid but do not participate because of enrollment barriers, poor retention, or lack of information."[33] Sommers further explains, "states anticipate that many such uninsured individuals will come out of the woodwork and sign up for Medicaid under the PPACA, thanks to heavy media coverage, streamlined enrollment procedures required by the law, and the individual mandate to obtain insurance."[34] Additionally, states fear that when some people investigate whether they can receive health insurance through one of the Exchanges, they will discover that they qualify for Medicaid, further increasing enrollees.[35] These individuals may then sign up for Medicaid.[36]

C. Large Administrative Costs

Although typically lower than the cost of covering newly eligible individuals, a number of states argue that the administrative costs for new Medicaid enrollment will be the second largest cost that they face.[37] Some state officials have stated that although the federal government will fully fund the expansion for the first three years, in addition to eventually being

32. Heberlein et al., *supra* note 4.
33. Sommers, *supra* note 5.
34. *Id.*
35. *Will Medicaid Bring The Uninsured Out Of The Woodwork?*, NAT'L PUB. RADIO (July 11, 2012) (*available at* http://m.npr.org/news/U.S./156568678).
36. *Id.*
37. Bovbjerg et al., *supra* note 7, at vi.

responsible for ten percent of the cost of services, states will also have to cover one-half of all additional administrative costs.[38] Administrative costs include conducting eligibility determinations and enrolling beneficiaries, administering fair hearings to resolve disputes regarding eligibility or coverage, credentialing individual practitioners and surveying and certifying institutional providers, and detecting and prosecuting fraud and abuse.[39] Administration is often projected as a flat five to eight percent of all new spending on benefits or managed care organization premiums.[40] Additionally, some states fear the fiscal strain that would result from revamping administrative procedures necessary in order to accommodate the enrollment of millions of new beneficiaries.[41]

IV. REASONS STATES WILL LIKELY DECIDE TO EXPAND MEDICAID

A. Long-term Savings of Health Care Costs

States will see long-term healthcare cost savings as a result of the Medicaid expansion. In particular, expanding Medicaid and providing coverage to young uninsured individuals will decrease the amount states spend on lifetime health care costs. The newly eligible individuals include 7.8 million adults under the age of thirty-five.[42] Roughly twenty-six percent of uninsured individuals who would be eligible for coverage are between the ages of nineteen and twenty-four, another twenty-six percent are

38. Antos, *supra* note 15, at 180.

39. Andy Schneider et al., Chapter IV: Medicaid Administration, KAISER COMM'N ON MEDICAID AND THE UNINSURED 129, *available at* http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14262.

40. Bovbjerg et al., *supra* note 7, at vi.

41. Sommers, *supra* note 5.

42. Genevieve M. Kenney et al., *Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage? Timely Analysis of Immediate Health Policy Issues*, URBAN INST. 1, 2 (2012), *available at* http://www.urban.org/UploadedPDF/412630-opting-in-medicaid.pdf.

between the ages of twenty-five and thirty-four, and thirteen percent are between the ages of fifty-five and sixty-four.[43] Studies have shown uninsured individuals are more likely to use high-priced emergency care services or become hospitalized for reasons that could have been avoided with preventive care.[44] A significant consequence for those uninsured is worse overall health, as about twenty percent of adults who were uninsured for at least one year reported they were in fair or poor health, compared to about eleven percent with continuous health coverage.[45] Furthermore, since access to health care is essential for preventive care measures and early diagnoses, coverage for younger uninsured individuals may offset high health costs in the future.

Additionally, approximately two million uninsured adults between the ages of fifty-five and sixty-four would gain Medicaid coverage under the PPACA.[46] Research shows increased coverage for this age group could reduce future health care costs because lack of coverage before reaching Medicare age is associated with greater utilization and higher expenditures under Medicare.[47] Thus, although Medicare is entirely funded by the federal government, some of the high costs of Medicare would be offset when those individuals would receive health care coverage under Medicaid.

A study conducted by the Robert Wood Johnson Foundation used a Health Insurance Policy Stimulation Model (HIPSM) to produce a consistent set of estimates for federal and state spending and savings. The model found that while the federal government would spend $704 billion to

43. *Id.*
44. Nan L. Maxwell, *Health Care Coverage in the United States*, UPJOHN INST. FOR EMP'T RESEARCH 1, 3 (2012), *available at* http://research.upjohn.org/up_bookchapters/816.
45. *Id.* at 2.
46. Kenney et al., *supra* note 44, at 5.
47. *Id.*

$743 billion more under the PPACA, states would spend ninety-two billion dollars to $129 billion less with the expansion than without the expansion over the same time period, between 2014 and 2019.[48] The study found while state spending on additional enrollees will rise by eighty billion dollars, the costs would be offset by sixty billion dollars in new federal spending on existing enrollees under the PPACA.[49]

B. Reduction of Mental Health Costs

Moreover, the Robert Wood Johnson Foundation study found that another source of savings for states would be the reduction of current spending on individuals with mental illnesses.[50] These savings result because state and local governments currently use general funds to pay for a large portion of state mental health costs.[51] In fiscal year 2008, state mental health agencies spent an estimated $36.8 billion,[52] and of this amount, 45.4%, or $16.7 billion, represented state and local costs outside of Medicaid.[53] Medicaid paid for forty-six percent of state mental health services, or $16.9 billion.[54] Among the adults served by state mental health agencies, 79% are either unemployed or outside the labor force.[55] Nevertheless, forty-three percent of consumers served by these agencies

48. Matthew Buettgens, Stan Dorn & Caitlin Carroll, *Consider Savings as Well as Costs State Governments Would Spend at Least $90 Billion Less With the ACA than Without It from 2014 to 2019*, URBAN INST. 1 (July 2011), *available at* http://www.urban.org/UploadedPDF/412361-consider-savings.pdf.

49. *Id.*

50. *Id.*

51. *Id.*

52. Matthew Buettgens & Stan Dorn, *Net Effects of the Affordable Care Act on State Budgets*, URBAN INST. 1, 4 (2010), *available at* http://www.urban.org/UploadedPDF/1001480-Affordable-Care-Act.pdf.

53. *Id.*

54. *Id.*

55. *Id.*

have no Medicaid coverage.[56] When the PPACA is fully implemented, Medicaid coverage is expected to increase from 12.4 to 23.3% of individuals with mental illness or substance abuse disorders, and Medicaid's mental health spending is projected to rise by 49.7%.[57] Using twenty-five to fifty percent of these federal dollars to substitute for state and local spending, states could collectively save between eleven billion dollars and twenty-two billion dollars from 2014-2019.[58]

C. Significant Federal Subsidies

Although states have the option to opt out of accepting the funds to expand Medicaid eligibility, studies indicate state officials who choose to opt out will suffer a loss of potential savings. A report prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured analyzing the potential savings states could achieve under the PPACA between 2014 and 2019 found savings could range from $40.6 billion to $131.9 billion.[59] These savings come from the following areas: elimination of optional Medicaid coverage for adults over 133% of FPL and thus shifting them to federally funded subsidies in the exchange, the replacement of state and local spending on uncompensated care with federal Medicaid dollars, and the replacement of state and local spending on mental health services with federal Medicaid dollars.[60] The study found the greatest savings would result from uncompensated care savings.[61] The study analyzed and estimated the spending of state and local governments from

56. *Id.*
57. *Id.*
58. *Id.* at 2.
59. Buettgens et al., *supra* note 54, at 1.
60. *Id.*
61. *Id.* at 2.

examining state general fund dollars.[62]

A study conducted by RAND Corporation Technical for the Council of State Governments, which undertook a preliminary analysis of the impact of the PPACA on five states, found in Connecticut, for example, that although state Medicaid spending will increase, total state government spending on health care would be ten percent lower for the combined 2011-2020 period.[63] The study recognized that the expansion will increase the state's spending since, in the long run, the state will be required to pay ten percent of Medicaid costs for the newly eligible population, and that although this is far less than the traditional state share of Medicaid funding (ranging from fifty to twenty percent, depending on state's per capita income), it is more than the states would spend if these individuals remained uninsured.[64] However, the study found the Medicaid expansion would amount to a $300 million reduction in state spending in 2016.[65] The savings would mostly result from the federal subsidies available to residents who would have been otherwise covered by Connecticut's state-run health insurance program, SAGA (State-Administered General Assistance).[66] The researchers conducted their analysis using a microsimulation model developed by RAND researchers for the Comprehensive Assessment of Reform Efforts (COMPARE) project.[67] The model produces estimates of the effects of various coverage expansion policy changes on the number of people who newly obtain insurance and/or change sources of insurance, the

62. *Id*. at 4.
63. David Auerbach et al., *The Impact of the Coverage-Related Provisions of the Patient Protection and Affordable Care Act on Insurance Coverage and State Health Care Expenditures in Connecticut*, RAND HEALTH CORP., 1-2 (2011).
64. *Id*. at 3.
65. *Id*. at 2.
66. *Id*.
67. *Id*. at 5.

types of plans in which they choose to enroll, and the changes in private and public-sector spending.[68]

V. ANALYSIS

Although the counter-cyclical nature of Medicaid causes legitimate concerns for states, some economists generally view countercyclical government spending as a good thing since it protects household income and promotes consumption that fuels economic recovery.[69] During an economic downturn, Medicaid plays an important role as a program that expands to meet rising needs when the economy is weak.[70] Additionally, although state concerns of high administrative costs are valid, this perspective is short-sighted, as the federally subsidized expansion of Medicaid would replace costs of uncompensated care that largely come from other parts of state budgets.[71] These costs include state-funded insurance programs, public state and county hospitals, and community health centers.[72] Additionally, states may receive some help in paying for the new administrative costs due to a federal regulation proposed by Centers for Medicare and Medicaid Services (CMS) in November 2010 that could pay a ninety percent match rate for new eligibility and enrollment systems.[73]

Ultimately, it is likely states will accept the Medicaid expansion because the federal funding is too significant to bypass. As the federal government

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68. *Id.*
69. Sommers, *supra* note 5.
70. Leighton Ku, *CDC Data Show Medicaid and SCHIP Played a Critical Counter-Cyclical Role in Strengthening Health Insurance Coverage During the Economic Downturn*, CENTERS FOR DISEASE CONTROL & PREVENTION 2 (2003), *available at* http://www.cbpp.org/archiveSite/9-23-03health.pdf.
71. Sommers, *supra* note 5.
72. *Id.*
73. Bovbjerg et al., *supra* note 7, at vi.

will not fund partial Medicaid expansions but instead states must fully commit to expansion to receive any funds, the significant sum of funding will ultimately be too attractive for states to reject expansion. Medicaid expansion will extend health coverage to more than twenty million people.[74] Implementing the Medicaid expansion with other provisions will reduce the number of insured people. According to Stanford University health economist Dr. Jay Bhattacharya, "If enough states decide to deny the Medicaid expansion, this may substantially reduce the ability of the PPACA [] to expand insurance coverage."[75] Although not the only step, every state expanding Medicaid is an important step for universal health coverage.

Furthermore, the National Association of Public Hospitals and Health Services (NAPH) estimates that the United States will spend as much as $53.3 billion more on bills that go unpaid by the uninsured.[76] Using data from various nationally recognized sources, NAPH projects hospitals will see $53.3 billion more uncompensated care costs by 2019 than originally estimated when lawmakers approved the PPACA.[77]

Moreover, states should act promptly to expand Medicaid because to do otherwise would harm states. According to Cindy Mann, deputy administrator of CMS, while there is no deadline for expanding Medicaid, states would pay a price for delay.[78] She explains that the federal payment

74. John Holahan et al., *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, KAISER COMM'N ON MEDICAID AND THE UNINSURED 1 (2011), *available at* http://www.kff.org/medicaid/upload/8384.pdf.

75. Ornstein, *supra* note 20.

76. *Need for a Sustainable Solution: Restoring the Balance in Safety Net Financing*, NAT'L ASS'N OF PUB. HOSPS. & HEALTH SERVS. 1 (2012), *available at* http://www.naph.org/Links/ADV/NAPHuncompensatedcareanalysis.aspx.

77. *Id*.

78. Robert Pear, *Administration Advises States to Expand Medicaid or Risk Losing Federal Money*, N.Y. TIMES, Oct. 2, 2012, at 1-2, *available at* http://www.nytimes.com/2012/10/02/us/us-advises-states-to-expand-medicaid-or-risk-losing-funds.html?ref=robertpear&_r=0.

rates "are tied by law to the specific calendar years noted" since under the new law the federal government will pay the entire cost of Medicaid coverage for newly eligible beneficiaries for three years, from 2014 to 2016 and the federal share will decline to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019 and 90 percent in 2020 and later years.[79] Therefore, if a state defers the expansion of Medicaid to 2016, the federal government will pay 100% of the costs for only 1 year.[80] After 2016, the federal share will drop to the levels specified by Congress, and states will be responsible for the remainder.[81] Furthermore, states are also likely to accept the federal funding for the Medicaid expansion because of the freedom and flexibility to drop the coverage. According to Mann, "a state may choose whether and when to expand, and if a state covers the expansion group, it may decide later to drop the coverage."[82]

VI. CONCLUSION

There are many reasons for states to accept the federal government's funding to expand Medicaid. While there are many social benefits to health care reform, states are likely to benefit financially from deciding to expand Medicaid. As the U.S. Supreme Court recognized, the federal government cannot require states to expand Medicaid without Congress overstepping its powers. Nevertheless, the financial reasons for extending Medicaid coverage are significant. While health care reform may cost states down the road, states will also experience great savings in other state and locally funded expenditures. Overall, despite the costs of expansion state officials will likely not reject the expansion of Medicaid to its citizens.

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79. *Id.* at 2.
80. *Id.*
81. *Id.*
82. *Id.* at 1.