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Laura D. Hermer
Mitchell Hamline School of Law, laura.hermer@mitchellhamline.edu

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MEDICAID: WELFARE PROGRAM OF LAST RESORT, OR SAFETY NET?

Laura D. Hermer†

I. INTRODUCTION

Peril to Medicaid exists on many different fronts.[1] In 2017, Congress nearly succeeded in fundamentally altering Medicaid by capping federal expenditures on it, regardless of need, and ending eligibility for many Americans.[2] Medicaid reimbursement to providers is also very much at risk, jeopardizing not only access to coverage for Medicaid beneficiaries, but access to care, as providers reduce or end their participation in the program.[3]

Meanwhile, both the Centers for Medicare and Medicaid Services (CMS) and a number of states are eager to make other, smaller-scale changes to the program.[4] These changes, while

† Laura Hermer is a Professor of Law at Mitchell Hamline School of Law.

1. *See infra* Part VI.

2. American Health Care Act of 2017, H.R. 1628, 115th Cong. (2017), https://www.gpo.gov/fdsys/pkg/BILLS-115hr1628pcs/pdf/BILLS-115hr1628pc s.pdf [https://perma.cc/2ZVD-3AAL]; Better Care Reconciliation Act of 2017, H.R. 1628, 115th Cong. (2017), https://www.budget.senate.gov/imo/media/doc/SENATEHEALTHCARE.pdf [https://perma.cc/GJ2D-9U2C].

3. *See infra* Part V.

4. *See generally* Kimberly Leanord, *Nine States Ready to Require Jobs for Medicaid Enrollees*, WASH. EXAMINER (Jan. 13, 2018, 12:01 AM), https://www.washingtonexaminer.com/nine-states-ready-to-require-jobs-for-medicaid-enrollees [https://perma.cc/RU4C-DMEJ] (outlining state efforts to

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narrower in impact, have substantial potential to reframe Medicaid from a broad safety net program for lower-income people who lack access to employer-sponsored health insurance, to a limited, short-term, stigmatized welfare program for the needy—one that is difficult to access and even more difficult to keep.[5]

This article will discuss these different and perilous fronts. In the process, it will suggest better and worse ways, as a matter of both law and public policy, to address the existential, financial, and political challenges facing Medicaid, its beneficiaries, and participating providers.

II. THE MEDICAID PROGRAM

Medicaid is our largest public health coverage program.[6] Enacted in 1965 along with Medicare, it plays a crucial role in multiple sectors of our health care system.[7] In 2016, the United States Census Bureau found that it covered 19.4% of the United States population, or approximately 62 million Americans.[8] It covers some of our most vulnerable citizens: the poor, children, elderly, and the disabled.[9] If not for Medicaid, many, if not most, of these

implement work requirements for Medicaid beneficiaries); Leslie Small, *Seema Verma Unveils Her Plan to "Turn the Page" on the Medicaid Program*, FIERCEHEALTHCARE (Nov. 7, 2017, 11:19 AM), https://www.fiercehealthcare.com/cms-chip/seema-verma-unveils-plan-to-turn-page-medicaid-program [https://perma.cc/F2TC-7MDK] (outlining an overview of CMS planned changes to Medicaid).

5. *See, e.g.*, MaryBeth Musumeci et al., *Medicaid and Work Requirements: New Guidance, State Waiver Details and Key Issues*, KAISER FAMILY FOUND. (Jan. 16, 2018), https://www.kff.org/medicaid/issue-brief/medicaid-and-work-requirements-new-guidance-state-waiver-details-and-key-issues/ (providing an example of Medicaid reform that would impose new barriers for Medicaid recipients—work requirements).

6. *Medicaid Pocket Primer*, KAISER FAMILY FOUND., https://www.kff.org/Medicaidfact-sheet/medicaid-pocket-primer/ [https://perma.cc/63M9-BN5L] (last visited July 31, 2018).

7. *See CMS' Program History*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/About-CMS/Agency-information/History/ [https://perma.cc/2WSM-6HR6] (last visited July 31, 2018) (discussing the history of Medicaid and the different groups covered).

8. JESSICA C. BARNETT & EDWARD R. BERCHICK, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2016 4 (2017), https://www.census.gov/content/dam/Census/library/publications/2017/demo/p60-260.pdf [https://perma.cc/FNS4-EEK8].

9. 42 U.S.C. § 1396a(a)(10)(A)(i) (2017).

individuals would be without other coverage options.[10] Medicaid also provides a major portion of the funds that safety net providers like community health centers, public hospitals, and other entities receive.[11] It substantially expands the federal dollars available in every state to pay for health care services, because of the federal government's majority share of Medicaid funding.[12] At the same time, Medicaid, like all health coverage, is quite expensive despite being less expensive per capita than either private coverage or Medicare.[13] This is largely because in most states Medicaid reimburses providers at a substantially lower rate than most other forms of coverage.[14]

Medicaid is a very complex program. Even a matter as simple as determining who qualifies for Medicaid coverage is not intuitive, and varies from state to state.[15] To qualify for Medicaid, an applicant must meet both categorical and income eligibility standards.[16] The

10. *See, e.g.*, Katherine Schwartz, *Health Care for the Poor: For Whom, What Care, and Whose Responsibility?*, 26 FOCUS 69, 71–72 (2009) (noting that prior to the enactment of the Affordable Care Act, less than half of those who earned less than 200% of the federal poverty level had private coverage, due to both access and affordability issues).

11. *See, e.g.*, Sara Rosenbaum et al., *Community Health Centers and the Evolution of Medicaid Payment Reform*, THE COMMONWEALTH FUND (Oct. 11, 2016), http://www.commonwealthfund.org/publications/blog/2016/oct/Co mmunity-health-centers-medicaid-payment-reform [https://perma.cc/NQ2A-DR MK] ("Medicaid plays a major role in supporting health centers, representing 44 percent of all health center revenues in 2015.").

12. 42 U.S.C. § 1396d(b) (2016) (setting the federal medical assistance percentage (FMAP) using a formula and setting the minimum federal share at 50% of state Medicaid expenditures and the maximum share at 83%).

13. Teresa A. Coughlin et al., *What Difference Does Medicaid Make? Assessing Cost Effectiveness, Access, and Financial Protection Under Medicaid for Low-Income Adults*, KAISER FAMILY FOUND. 7 (2013), https://kaiserfamilyfoundation.files.word press.com/2013/05/8440-what-difference-does-medicaid-make2.pdf [https://per ma.cc/4N9E-FF4H] (finding that projected costs for low-income, adult Medicaid beneficiaries would have been approximately 25% higher during the study period (2003–2009) had they used private, employer-sponsored coverage instead).

14. Samantha Artiga et al., *Current Flexibility in Medicaid: An Overview of Federal Standards and State Options*, KAISER FAMILY FOUND. (Jan. 31, 2017), https://www.kff.org/report-section/current-flexibility-in-medicaid-issue-brief/ [ht tps://perma.cc/WGW6-L3TF] (noting that, while individual state rates differ, on average states pay fee-for-service physicians only 66% of Medicare rates).

15. *See, e.g.*, *Medicaid Pocket Primer*, *supra* note 6 (providing basic information on Medicaid).

16. *Id.*

federal government sets the baseline standards, and each state may then build upon them if it wishes.[17] Medicaid traditionally covered low-income children, parents of dependent children, elderly and disabled people, and later on, pregnant women.[18] These are "mandatory" populations, meaning that a state must cover these populations at the minimum income eligibility levels if it wants to have a Medicaid program at all.[19] On the other hand, optional populations can be covered if a state chooses to do so.[20] Those optional populations include mandatory populations at higher income levels.[21] It also includes Medicaid "spend down" populations, or people who meet categorical eligibility, but only meet income eligibility if their uninsured medical expenses are subtracted from their income.[22] The ACA expansion population—all non-elderly adults earning 133% of the federal poverty level or less who do not otherwise qualify for Medicaid—are also deemed to be an optional population.[23]

Different Medicaid populations consume very different amounts of health care. Thus, while children constitute nearly half of enrollees, they only account for about a fifth of Medicaid costs.[24] The elderly and disabled, on the other hand, account for nearly two-thirds of costs while only comprising about a quarter of total

17. *See, e.g.*, 42 U.S.C. § 1396a(a)(10)(A)(i) (2017); 42 C.F.R. §§ 435.110(c) (relating generally to parents), .116(c) (relating to pregnant women), .117(b) (relating to newborns), .118(c) (relating to children under age 19), .119(b) (relating to non-elderly adults), .120 (relating to individuals receiving Supplemental Security Income) (2017).

18. *See* Pub. L. 89–97, § 1905(a)(i)–(v), 79 Stat. 286, 351 (1965) (codified as enacted at 42 U.S.C. § 1396d (2016)) (providing that assistance under Medicaid may be provided to individuals under age 21, relatives with whom dependent children are living, the elderly, and the blind or disabled); 42 C.F.R. § 435.116(b) (2017) (mandating that Medicaid cover pregnant women below a certain income level).

19. *See* 42 C.F.R. §§ 435.110(b) (relating generally to parents), .116(b) (relating to pregnant women), .117(b)(1) (relating to newborns), .118(b) (relating to children under age 19), .120 (relating to individuals receiving Supplemental Security Income) (2017).

20. *Id.* § 435.201.

21. *Id.* § 435.201(a).

22. *Id.* § 435.301(a)–(b).

23. *Id.* § 435.119; *see also* Nat'l Fed. Indep. Bus. v. Sebelius, 567 U.S. 519, 585 (2012) (making the Medicaid expansion optional for states).

24. *See Medicaid Pocket Primer*, *supra* note 6.

enrollees.[25] This becomes important when considering the potential impact that block-granting federal Medicaid support would have on each state's program—an issue we will return to below.[26]

It is critical to note that Medicaid is not only an optional program for states, but also one that effectively has two masters—the state and the federal government. As a cooperative federal/state program enacted under the Spending Clause of the Constitution, the federal government sets the baseline for eligibility, benefits, and certain other matters.[27] If a state meets those baselines in its Medicaid program, and moreover adheres to the other requirements set by the federal government, then it has substantial latitude to develop its own Medicaid program.[28] For example, a state can cover children and pregnant women at a much higher income level or offer certain optional services like prescription drugs, dental care, and hospice services.[29] The state can also seek special permission from the federal government under § 1115 of the Social Security Act for a waiver from certain federal rules so it can experiment with its Medicaid program.[30]

The federal and state governments jointly fund Medicaid expenditures.[31] A comparatively wealthy state like Minnesota, for example, is responsible for 50% of the state's Medicaid expenditures and the federal government is responsible for the remaining 50%.[32]

25. *Id.*

26. *See infra* Part V.

27. *See, e.g.*, *Sebelius*, 567 U.S. at 629 (2012) (Ginsburg, J., dissenting) ("Medicaid 'is designed to advance cooperative federalism.'" (citation omitted)).

28. *Id.* ("Subject to its basic requirements, the Medicaid Act empowers States to 'select dramatically different levels of funding and coverage, alter and experiment with different financing and delivery modes, and opt to cover (or not to cover) a range of particular procedures and therapies. States have leveraged this policy discretion to generate a myriad of dramatically different Medicaid programs over the past several decades.'" (citation omitted)).

29. *Id.*

30. 42 U.S.C. § 1315(a) (2017). For more on § 1115 Medicaid waivers, *see infra* Part VI.

31. 42 U.S.C. § 1396d(b) (2016).

32. *See, e.g.*, *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*, KAISER FAMILY FOUND., https://www.kff.org/medicaid/state-indicator/Federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22ColId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/4TQ9-H7GX] (last visited July 31, 2018).

A state with a lower average income level such as Alabama, is responsible for less than 30% of its Medicaid costs.[33]

III. CHANGES TO MEDICAID UNDER THE AFFORDABLE CARE ACT

The ACA, as written, expands Medicaid to all non-elderly individuals earning less than 133% of the federal poverty level.[34] To make the expansion less costly for states, the federal government covered 100% of the costs for newly eligible adults through 2016.[35] The federal matching percentage fell to 95% in 2017, and will reduce to a floor of 90% in 2020.[36] States are responsible for the remaining costs.[37] But in *NFIB v. Sebelius*, the Supreme Court made the Medicaid expansion optional for states.[38] Justice Roberts characterized the mandatory nature of the expansion under the terms of the ACA as a "gun to the head" of the states since, if a state refused to expand Medicaid under the ACA, Health and Human Services could withhold all of a state's Medicaid funds as a penalty.[39]

Twenty-five states and the District of Columbia expanded their Medicaid programs as provided by the ACA.[40] Eight other states, to date, have taken up the Medicaid expansion, but did so using a § 1115 waiver or other, non-standard means.[41] Altogether, an additional 15 million Americans are now covered under state

33. *Id.* (showing that the federal government pays 71.44% of Alabama's Medicaid expenditures).

34. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2016). The income limit is often identified as 138% of the federal poverty level, because the ACA incorporates a 5% income disregard into the calculation of an individual's gross income for Medicaid and private insurance subsidy eligibility. *See id.* § 1396a(e)(14)(I).

35. *Id.* § 1396d(y)(1)(A).

36. *See id.* § 1396d(y)(1)(B)–(E).

37. *Id.* § 1396d(y)(1); *see id.* § 1396d(b).

38. Nat'l Fed. Indep. Bus. v. Sebelius, 567 U.S. 519, 585 (2012).

39. *Id.* at 581.

40. *Status of State Action on the Medicaid Expansion Decision*, KAISER FAMILY FOUND., https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/5PFN-KLWC] (last visited July 31, 2018) (listing every state's decision about adopting the Medicaid expansion as of January 16, 2018).

41. *Id.*

Medicaid expansions.[42] Nineteen states[43] still refuse to expand their Medicaid programs under the ACA; most of these states are in the South and Midwest.[44] If the ACA had gone into effect as planned, approximately *2.4 million more* Americans would have coverage under Medicaid.[45]

While evidence is slower to accumulate on the impact of health outcomes for Medicaid expansion populations, many other measures, show substantial improvements for Medicaid beneficiaries. The Medicaid expansion has significantly expanded access to coverage for lower-income populations.[46] It is also correlated with more significant smoothing of coverage disparities between lower-income and higher-income Americans.[47] Access to care for expansion populations increased.[48] For example, one study

42. *Medicaid Expansion Enrollment*, KAISER FAMILY FOUND., https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/KF78-A93B] (last visited July 31, 2018).

43. This figure includes Maine. Maine voters approved a referendum in November 2017 to expand Medicaid under the ACA, but Governor LePage has, to date, refused to execute it. Press Release, Office of Governor Paul R. LePage, Governor LePage Issues Statement on Medicaid Expansion (Nov. 8, 2017), http://www.maine.gov/tools/whatsnew/index.php?topic==GOV+News&id=771214&v=article2011 [https://perma.cc/JN8N-9T2F] ("[M]y administration will not implement Medicaid expansion until it has been fully funded by the Legislature at the levels DHHS has calculated.").

44. *See Status of State Action on the Medicaid Expansion Decision*, *supra* note 40.

45. Rachel Garfield & Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KAISER FAMILY FOUND. (Nov. 1, 2017), https://www.kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/ [https://perma.cc/D2EK-5Y66].

46. *See, e.g.*, Stacey McMorrow et al., *The ACA Medicaid Expansion Led to Widespread Reductions in Uninsurance Among Poor, Childless Adults*, U.S. HEALTH REFORM—MONITORING & IMPACT 2–6 (Apr. 2017), https://www.urban.org/sites/Default/files/publication/89536/2001222-aca_medicaid_expansion_led_to_Widespread_reductions_in_uninsurance_among_poor_childless_adults.pdf [https://perma.cc/C8Q2-2XB7] (finding that the uninsured rate for poor, childless adults in Medicaid expansion states fell from 45.4% in 2013 to 16.5% in 2015).

47. *See* Kevin Griffith et al., *The Affordable Care Act Reduced Socioeconomic Disparities in Health Care Access*, 36 HEALTH AFF. 1503, 1506 (2017).

48. *See generally* Larisa Antonisse et al., *The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review*, KAISER FAMILY FOUND. (Sept. 25, 2017), https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-september-2017/ [https://perma.cc/4CC5-JLLM] (discussing different studies showing that expanded Medicaid

found that expansion-eligible adults in the expansion states of Arkansas and Kentucky were significantly more likely to obtain care for chronic conditions than the same population in the non-expansion state of Texas.[49] While it is not yet clear that having Medicaid coverage translates unambiguously into better outcomes for specific health conditions, it offers improved affordability of care, access to health care services, and peace of mind to its beneficiaries.[50] Finally, the Medicaid expansion also helps hospitals' bottom lines, as their uncompensated care bills have declined.[51]

IV. RESPONSES TO THE ACA'S MEDICAID CHANGES

When the ACA was enacted, some states, and many organizations, were quick to lambast the Act's Medicaid expansion on several different fronts. Texas notably threatened to end Medicaid altogether, citing excessive costs.[52] However, after evaluating the financial impact that abolishing its Medicaid program would have on the state, legislators realized that Texas would lose billions of dollars per year in federal funding, while continuing to subsidize other states' programs through federal tax payments.[53]

The Republican Governors' Association (RGA) expressed concern about "federal restrictions" on state control of Medicaid and

populations led to increased access to care; however, some studies did not show any significant changes).

49. Benjamin D. Sommers et al., *Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance*, 314 J. AM. MED. ASS'N 366, 370 (2016).

50. Stacey McMorrow et al., *Medicaid Expansion Increased Coverage, Improved Affordability, And Reduced Psychological Distress for Low-Income Parents*, 36 HEALTH AFF. 808, 817 (2017).

51. David Dranove et al., *Uncompensated Care Decreased at Hospitals in Medicaid Expansion States but not at Hospitals in Nonexpansion States*, 35 HEALTH AFF. (2016).

52. *See, e.g.*, R.G. Ratcliffe, *Report Warns Medicaid Opt-Out Would Sting Texas Health Care*, HOUSTON CHRON. (Dec. 3, 2010, 6:30 AM), http://www.chron.com/news/houston-texas/article/Report-warns-Medicaid-opt-out-would-sting-Texas-1591666.php [https://perma.cc/5QTV-Q698] ("Gov. Rick Perry and some lawmakers have been saying Texas, in the face of an $18 billion-plus budget shortfall, should consider opting out of the voluntary federal medical care program for the poor.").

53. TEX. HEALTH & HUMAN SERVS. COMM'N & TEX. DEP'T OF INS., IMPACT ON TEXAS IF MEDICAID IS ELIMINATED: A JOINT REPORT REQUIRED BY HOUSE BILL 497, at 28 (2010) (finding, inter alia, that opting out of Medicaid would have cost Texas $15 billion in federal funds in 2009 alone, and that approximately 2.6 million Texans would lose coverage).

other programs in a 2011 letter to House Speaker Paul Ryan, writing that:

> The Patient Protection and Affordable Care Act . . . does not provide the flexibility states need for the challenges of today or tomorrow. Medicaid remains an antiquated, federal maze of regulations and mandates focused on process instead of quality health care. It requires months and sometimes years of negotiations for even modest changes, "perhaps" resulting in a positive outcome at the end of the process. This practice must stop if Governors are to contain costs and provide a safety net for our citizens; we know their needs far better than the federal government. We cannot do the jobs we were elected to do while continuing to be hampered by a federal program that stifles innovation and handcuffs state flexibility.[54]

The RGA instead advocated block-granting Medicaid, an issue I will return to below.[55]

Finally, many right-wing commentators started questioning the utility of Medicaid. They alleged not merely that privately-insured patients do better than Medicaid patients on a variety of treatment outcomes, but also that uninsured patients fare as well as, if not better than, Medicaid patients.[56] They claim this is due to Medicaid's typically poor provider reimbursement, which in turn "constrains [patients'] access to doctors," as well as to better specialists.[57] Consequently, they concluded it would be better to allow states substantial flexibility to tailor their Medicaid plans, or to provide

54. *RGA Leadership Supports House GOP Budget; Calls for Medicaid Block Grants,* RGA NEWS (Apr. 5, 2011), https://www.rga.org/rga-leadership-supports-house-gop-budget-calls-for-medicaid-block-grants/ [https://perma.cc/3DXY-47NR].

55. *Id.*; *see also* infra Part V.

56. *See, e.g.*, John Goodman, *Is Medicaid Real Insurance?*, KAISER HEALTH NEWS (Mar. 25, 2011), https://khn.org/news/032511goodman/ [https://perma.cc/A3DS-YYVQ] (opining that "[i]t would appear at the margin that there's not much difference" between having Medicaid and being uninsured); Avik Roy, *How Medicaid Harms the Poor: A Counter-Rebuttal, Part II*, FORBES: THE APOTHECARY (Mar. 10, 2011, 11:43 AM), https://www.forbes.com/sites/theapothecary/2011/03/10/how-medicaid-harms-the-poor-a-counter-rebuttal-part-ii/#5f49c2446df1 [https://perma.cc/PPD3-M7L8] (arguing that poor reimbursement from Medicaid harms both the quality and quantity of beneficiaries' care).

57. Roy, *supra* note 56.

vouchers to Medicaid beneficiaries to help purchase private coverage instead.[58]

Public opinion sided for a while with the ACA naysayers. Prior to the ACA's enactment, polling by the Pew Research Center indicated that a majority of Americans believed the government had a responsibility to ensure coverage.[59] This percentage dropped dramatically as Congress debated, and then enacted, the ACA.[60] However, once the public was faced with the prospect that the ACA's coverage expansions would be eliminated after Trump's election in 2016, the percentage of Americans agreeing that the government has a responsibility to ensure coverage for all Americans rose to its pre-ACA majority.[61]

The public supports Medicaid even more than it supports the proposition that the government has a responsibility to ensure coverage. Nearly three out of four people polled in June 2017 by the Kaiser Family Foundation had a very or somewhat favorable view of Medicaid.[62] While its popularity among Democrats was stronger, even a majority of Republicans—61%—had a very or somewhat favorable view of the program.[63]

58. Scott Gottlieb, *Medicaid Is Worse Than No Coverage at All*, WALL STREET J. (Mar. 10, 2011, 12:01 AM), https://www.wsj.com/articles/SB10001424052748704758904576188280858303612 [https://perma.cc/2QX7-P9FL] (arguing in favor of substantially increased state flexibility); Roy, *supra* note 56 (arguing that the poor should be given funds to help them obtain private coverage, or alternatively, that Medicaid should be converted "into a block grant program, whereby the federal government gives the states free rein to compare market-oriented and socialized approaches to Medicaid").

59. Pew Research Center, *Poll Support for Single-Payer Health Coverage Grows, Driven by Democrats* (June 23, 2017), http://www.pewresearch.org/fact-tank/2017/06/23/public-support-for-single-payer-health-coverage-grows-driven-by-democrats/ft_17-06-23_healthcare_responsible/ [https://perma.cc/7VLZ-2UA8] (finding that, between 2000 and 2008, most Americans believed the government is responsible for ensuring health coverage).

60. *Id.* (showing that, between 2009 and about 2014, public opinion regarding this question started at about 50% and ultimately dropped to 42%).

61. *Id.* (showing that, between 2014, when the ACA coverage expansions went into effect, and 2016, the percentage agreeing with the question rose to around 50%, and then increased to 60% going into 2017, as the ACA repeal bills were being considered).

62. *Kaiser Health Tracking Poll–June 2017: ACA, Replacement Plan, and Medicaid*, KAISER FAMILY FOUND. (June 23, 2017), https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-june-2017-aca-replacement-plan-and-medicaid/ [https://perma.cc/FEJ6-GTCW].

63. *Id.*

This similarly holds true for people's view of how Medicaid is working for those it covers. Despite claims that Medicaid does not work and yields worse outcomes for those covered than simply being uninsured, a clear majority of those polled—including Republicans—believed Medicaid generally works well.[64] Additionally, most respondents had a positive opinion of how Medicaid is working in their own state.[65] Finally, and most notably, a majority of those polled want Medicaid spending to increase or remain the same, rather than be reduced.[66]

V. CONGRESSIONAL ATTEMPTS TO ALTER MEDICAID

None of this, however, has stopped congressional attempts to take a very different approach to Medicaid. Longstanding efforts by Republicans have sought to reduce the role of the federal government in providing or administering health benefits. For example, they have sought to limit the government's involvement to subsidizing private coverage and arranging coverage for only the sickest and poorest citizens.[67] Proponents of these efforts have sought to treat Medicaid as a welfare program, in the stigmatized sense of a handout for the needy, rather than as a health coverage program.[68] They hold that only the most vulnerable—for example, those who are permanently disabled and cannot work—should get Medicaid coverage.[69] Until the law is changed to end Medicaid eligibility for the so-called "able-bodied" poor, proponents of these efforts believe that states should be able to take steps to actively push

64. *Id.*

65. *Id.*

66. *Id.* at fig. 17.

67. *See, e.g.*, David G. Smith & Judith D. Moore, *Medicaid Politics and Policy: 1965–2007* 155–65 (discussing, inter alia, the attempt to impose an annual 5% cap on federal Medicaid matching fund increases in the Omnibus Budget Reconciliation Act of 1981 and the attempt in the same year to block grant Medicaid).

68. *See, e.g.*, HOUSE COMMITTEE ON THE BUDGET, THE PATH TO PROSPERITY: RESTORING AMERICA'S PROMISE 39–40 (2011), http://budget.house.gov/UploadedFiles/PathToProsperityFY2012.pdf [https://perma.cc/FC6V-4CXK] (advocating the block-granting Medicaid, in conjunction with substantial state programmatic flexibility).

69. Ctrs. Medicare & Medicaid Servs., Remarks by Administrator Seema Verma at the National Association of Medicaid Directors (NAMD) 2017 Fall Conference (Nov. 7, 2017), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-07.html [https://perma.cc/2Z7D-HXNG].

this class of beneficiaries out of public assistance programs.[70] As one step toward that end, Republicans have advocated devolving authority for Medicaid to state governments and providing them with set amount of federal funds.[71] These funds would either be capped per capita among each state's Medicaid population or set in a fixed amount per state.[72] Such a plan would both reduce and smooth federal funding for Medicaid.[73] However, barring the creation of significant new efficiencies, the medical needs—and costs—of the affected populations would remain.[74] We need only to turn to the former cash welfare entitlement program, Aid to Families with Dependent Children (AFDC), to see what happens when a major entitlement program is block-granted. When AFDC was eliminated in 1996 and replaced with the block-granted, time-limited, non-entitlement Temporary Aid to Needy Families

70. Ms. Verma noted with respect to Medicaid parents and the expansion population that:

> We owe our fellow citizens more than just giving them a Medicaid card, we owe a card with care, and more importantly a card with hope. Hope that they can achieve a better future for themselves and their families. Hope that they can one day break the chains of generational poverty and no longer need public assistance, and the hope that every American, no matter their race, creed, or origin, can reach their highest potential. We will approve proposals that accomplish this goal."

Id.

71. *See, e.g.*, HOUSE COMMITTEE ON THE BUDGET, *supra* note 68, at 39–40.

72. *Id.*

73. *See, e.g.*, Jeanne Lambrew, *Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals*, 83 MILBANK Q. 41, 43 (2005).

74. *See, e.g.*, John Z. Ayanian et al., *Unmet Health Needs of Uninsured Adults in the United States*, 284 JAMA 2061, 2064 (2000) ("[N]early two fifths of long-term uninsured adults and one third of short-term uninsured adults reported [not being able to see a physician due to cost], compared with only about 1 in 14 insured adults.").

program (TANF), cash welfare for most single mothers ended.[75] Poverty, however, did not.[76]

In 1981, 1995, and 2003, Republicans tried to block grant Medicaid in the same way they block-granted cash welfare.[77] These efforts are once again underway.[78] In 2017, Congress proposed a repeal and replace bill that includes the commonality of a per capita cap on Medicaid expenditures with a state option to receive a block grant instead.[79] Under a block grant, as proposed in some of the recent ACA repeal and replace bills, states could opt to receive a fixed sum of federal dollars for their non-elderly, non-disabled, adult Medicaid population.[80] The base amount is calculated using a complex formula involving prior year spending and would rise based on the general inflation rate.[81] States would have broad flexibility to set eligibility conditions and benefits for populations covered by

75. *See, e.g.*, GENE FALK, THE TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) BLOCK GRANT: RESPONSES TO FREQUENTLY ASKED QUESTIONS 8 (Cong. Research Serv. ed., 2016) (noting that cash welfare participation declined from a high of 5.1 million families in 1994 to 1.6 million families in 2015). Putting it differently, the Center for Budget and Policy Priorities found that 68 out of every 100 families in poverty with a child received AFDC or TANF in 1996, as compared to only 23 out of every 100 such families in 2015. *Chart Book: Temporary Aid to Needy Families*, CTR. FOR BUDGET & POL'Y PRIORITIES (2017), https://www.cbpp.org/research/family-income-support/chart-book-temporary-assistance-for-needy-families [https://perma.cc/69D4-5H3W].

76. *See, e.g.*, Yonatan Ben-Shalom et al., *An Assessment of the Effectiveness of Anti-Poverty Programs in the United States* 15, tbl. 3 (Johns Hopkins U., Dep't of Econ., Working Paper No. 579, 2011), https://www.econstor.eu/bitstream/10419/49863/1/657590711.pdf [https://perma.cc/D3U4-4ZYQ] (finding that pre-transfer poverty rates declined slightly from 30% in 1993 to 29% in 2004, and that deep poverty rates (total income below 50% of the federal poverty level) increased slightly from 20.8% in 1993 to 21.3% in 2004).

77. *See, e.g.*, Colleen Grogan & Eric Patashnik, *Between Welfare Medicine and Mainstream Entitlement: Medicaid at the Political Crossroads*, 28 J. HEALTH POL. POL'Y & L. 821, 830, 843–46, 854 (2003) (detailing the politics of efforts to block grant Medicaid in those years).

78. American Health Care Act, H.R. 1628, 115th Cong. § 121 (2017); Better Care Reconciliation Act, H.R. 1628, 115th Cong. § 134 (2017), https://www.govtrack.us/congress/bills/115/hr1628/summary [https://perma.cc/Q4L3-33WC].

79. Graham-Cassidy Health Care Bill, S. Amdt.1030 to H.R.1628,115th Cong. (2017-2018), https://www.congress.gov/amendment/115th-congress/senate-Amendment/1030/text.

80. *Id.*

81. *Id.*

block grants—even broader than their present authority.[82] Unlike Medicaid's present status, where it is automatically funded, a block-granted Medicaid would need to be renewed either every ten years,[83] or every five years like the Children's Health Insurance Program (CHIP).[84] Similar to the struggles CHIP recently faced in winning congressional reauthorization,[85] it is possible that Medicaid would face nonrenewal, or, more likely, that funding could be tied up or made contingent on other issues.[86]

Representative Paul Ryan proposed the per capita cap as an alternative to block-granting Medicaid.[87] It was intended to become the default method of funding Medicaid under both the American Health Care Act ("AHCA") and the Better Care Reconciliation Act ("BCRA").[88] As proposed in those bills, the per capita cap would break down each state's Medicaid population into four categories: the elderly, the disabled, the non-elderly and non-disabled adults, and the children.[89] Each of the four groups would be subject to a different federal funding cap available for each group member.[90]

82. *Id.*

83. American Health Care Act, H.R. 1628, 115th Cong. § 134 (2017).

84. Better Care Reconciliation Act, H.R. 1628, 115th Cong. § 133 (2017).

85. *See, e.g.*, Sarah Kliff, *CHIP Is Finally Getting Funded – After 114 Days Without a Budget*, VOX (Jan. 22, 2018), https://www.vox.com/2018/1/22/16919640/chip-funding-congress-shutdown [https://perma.cc/8BSR-S6XC] (noting that Congress had let CHIP's funding lapse and had used CHIP as "a bargaining chip in larger negotiations over the federal budget and immigration" before ultimately reauthorizing the program for six years). Congress ultimately reauthorized CHIP for an additional four years. Valerie Brankovic, *President Signs Massive Two-Year Budget Agreement; Package Includes Funding for Key Health and Human Services Programs, Disaster Relief and Infrastructure*, NAT'L ASS'N COUNTIES BLOG (Feb. 13, 2018), http://www.naco.org/blog/president-signs-massive-two-year-budget-agreement-package-includes-funding-key-health-and-human [https://perma.cc/6KSX-WALP].

86. *See, e.g.*, Judy Baker, *Threatened Medicaid, CHIP Programs Are Vital to Our Health Care System*, ST. LOUIS POST-DISPATCH (Oct. 16, 2017), http://www.stltoday.com/opinion/columnists/threatened-medicaid-chip-programs-are-vital-to-our-health-care/article_fa65566f-c4eb-536c-96db-facd6834887 4.html [https://perma.cc/7VZH-29AT] (discussing that Congress could fail to renew Medicaid in addition to CHIP).

87. A BETTER WAY, A BETTER WAY: OUR VISION FOR A CONFIDENT AMERICA 25–28 (2016).

88. *Id.*

89. *Id.*

90. *Id.* Each of the four groups would be subject to a different funding cap due to the substantial differences in the different average medical costs of each group. *See Medicaid Pocket Primer*, *supra* note 6.

States would receive annual Medicaid funding based on the number of people in each group and the baseline spending for each group, adjusted as needed by either the general or medical inflation rate.[91]

Block-granting or per capita capping Medicaid would smooth out federal Medicaid funding and make it more predictable, rather than allowing it to expand and contract based on need.[92] However, it would come at a price. Block grants do not typically increase in the event of an economic downturn.[93] Thus, if an economic recession occurred after Medicaid were block-granted pursuant to the AHCA or the BCRA, and the number of people needing Medicaid coverage increased substantially, funding would not expand to meet the additional need.[94] Funding would also not automatically expand to meet the needs of states following natural disasters like hurricanes or floods.[95] A per capita cap system, as proposed in the bills, would avoid these problems, because funding would expand and contract based on the number of enrollees.[96] However, funding under both

91. American Health Care Act, H.R. 1628, 115th Cong. (2017); Better Care Reconciliation Act, H.R. 1628, 115th Cong. (2017), https://www.govtrack.us/Congress/bills/115/hr1628/summary [https://perma.cc/Q4L3-33WC].

92. *See, e.g.*, Lambrew, *supra* note 73 (block grants "would eliminate the 'uncontrollable' aspects of entitlement programs Congress sets in advance the maximum amount of federal block grant spending, which offers both predictability and a relatively easy way to adjust the program's spending to meet broader budget goals. Whereas federal policymakers could reduce the costs of entitlement programs through specific eligibility or benefits changes, it is probably politically easier for them to cut spending on block grants, thereby delegating these difficult decisions to states. Predetermined funding also limits the extent to which the states' actions influence federal outlays." (citations omitted)).

93. *Id.* at 55–56 (finding that "[t]he projections of what Medicaid spending would be three years into the future ranged from twenty-eight percent higher than the actual spending for the year 1996 to thirty-one percent lower for 1992," given the proposed structure of the block grants and what the actual need was during the study period).

94. See Edwin Park & Matt Broaddus, *Medicaid Block Grant Would Shift Financial Risks and Costs to States: States Would Bear Impact of Recessions, Higher Medical Costs*, CTR. FOR BUDGET & POL'Y PRIORITIES 4–5 (2011), https://www.cbpp.org/sites/default/Files/atoms/files/2-23-11health.pdf [https://perma.cc/4JCR-44GQ].

95. *See* Bruce Japsen, *How Trumpcare's Medicaid Block Grants Hurt Hurricane Victims*, FORBES (Sept. 24, 2017, 9:38 AM), https://www.forbes.com/sites/Brucejapsen/2017/09/24/how-graham-cassidys-medicaid-block-grants-dont-plan-for-hurricanes/#9ab05261f8a9 [https://perma.cc/KC4G-XX75].

96. *See* Gretchen Jacobson et al., *What Could a Medicaid Per Capita Cap Mean for Low-Income People on Medicaid*, KAISER FAMILY FOUND. (Mar. 24, 2017),

block grants and per capita caps would expand in most cases based on the urban consumer price index, rather than at the higher—and arguably more appropriate—medical inflation rate, and would therefore almost certainly fail to keep up with programmatic cost increases.[97]

The Minnesota Department of Human Services estimates that if Medicaid is changed to a per capita cap program and if the expansion is repealed, then Minnesota would lose approximately $4 billion in federal funds over the next two years.[98] There would almost certainly be additional losses beyond those highlighted in the report. That is quite a large hole for a state to fill. So, what do states do in the face of such funding cuts?

When Medicaid funding gets cut at either the state or federal level, one or more of the following four things tends to happen. First, states sometimes opt to raise taxes, usually on hospitals and other health care entities.[99] By raising taxes earmarked for Medicaid, states can amplify the tax dollars' effect through receipt of federal matching funds—as state Medicaid spending increases, so does corresponding federal Medicaid spending.[100] However, this would no longer be the case under either a block grant or a per capita cap system. This is because the amount of money that a state spends on its Medicaid program would have no impact on the amount of federal Medicaid funds it receives.[101] Second, states may tighten up

https://www.kff.org/medicare/issue-brief/what-could-a-medicaid-per-capita-cap-mean-for-low-income-people-on-medicare/ [https://perma.cc/Y8TZ-NTUW].

97. Lambrew, *supra* note 73, at 56. Lambrew found that even using medical cost inflation failed to account for even half of the cost increases in the program. *Id.* Rather, she found that other factors, such as changes in the proportion of elderly and younger beneficiaries and the proportion of rural versus urban beneficiaries, accounted for many disparities in how different states would have fared in her study. *Id.* at 53–54.

98. MINN. DEP'T OF HUMAN SERVS., REPEALING THE AFFORDABLE CARE ACT: IMPACTS TO MINNESOTA'S PUBLIC HEALTH CARE PROGRAMS 6 (2017), https://mn.gov/dhs/assets/aca-brief-010617_tcm1053-304368.pdf [https://perma.cc/G2UJ-QGNE].

99. *See, e.g.*, Biggs v. Betlach, 404 P.3d 1243, 1247–48 (2017) ("Hospital assessments are to 'be used for the benefit of hospitals for the purpose of providing health care for persons eligible for coverage funded by the hospital assessment' . . . [and] also [to] enable hospitals to be compensated for treating patients who are unable to pay." (citations omitted)).

100. 42 U.S.C. § 1396d(b) (2016).

101. *See* Jacobson et al., *supra* note 96.

eligibility.[102] Most states cover optional populations whom they can cut if they must and if politically feasible.[103] They can additionally, or alternatively, impose administrative barriers to obtaining or maintaining coverage that reduce Medicaid uptake and retention.[104] These options were curtailed by the ACA, but would be permitted under some of the repeal efforts proposed.[105] Third, states may cut benefits.[106] Most Medicaid programs cover a variety of optional benefits, such as prescription drugs, that states can, and do, cut back on if necessary.[107] Fourth, states may cut provider payments.[108] This may perhaps be one of the most common approaches, as it allows states to avoid making hard and politically unpopular choices about cutting Medicaid services while effectively doing so by disincentivizing physicians to provide services to Medicaid patients.[109] We could expect to see states making any or all these choices should Congress ever change Medicaid into a block-granted or per capita capped program.

102. *See, e.g.*, Robin Rudowitz & Caryn Marks, *Few Options for States to Control Medicaid Spending in a Declining Economy*, KAISER FAMILY FOUND. 4 (2008) https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7769.pdf [https://perma.cc/9TPN-K5MB] (summarizing some of the cuts states made to eligibility between 2002 and 2008).

103. *Id.*

104. *Id.*

105. *See Medicaid's Future: What Might ACA Repeal Mean*, COMMON WEALTH FUND, http://www.commonwealthfund.org/publications/issue-briefs/2017/jan/medicaids-future-aca-repeal [https://perma.cc/W42L-LM76] (last visited July 31, 2018); Charles Ornstein, *States Move to Tighten Medicaid Enrollment, Even Without a New Health Law*, NPR (Jan. 6, 2017 1:14 PM), https://www.npr.org/sections/health-shots/2017/07/06/535750231/states-move-to-tighten-medicaid-enrollment-even-without-a-new-health-law [https://perma.cc/3H3V-4HYT].

106. *Id.*

107. *See, e.g.*, Phil Galewitz, *States Cut Medicaid Drug Benefits to Save Money*, KAISER HEALTH NEWS (July 24, 2012) https://khn.org/news/medicaid-cuts-sidebar [https://perma.cc/QZ3S-8S33] (explaining that some states limit amounts of prescription drugs Medicaid beneficiaries can receive).

108. *Id.*

109. *See, e.g.*, Vernon Smith et al., *As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2007 and 2008*, at 26, KAISER FAMILY FOUND. (Oct. 2007), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7699.pdf (noting that, while state policy makers "recognize that provider payment rates are an important determinant of access and availability of services for Medicaid beneficiaries, . . . cutting or freezing provider payment rates was a primary policy option taken by states [in the late 2000s] to help control Medicaid spending").

VI. MEDICAID'S PROSPECTS

Medicaid's prospects appeared bleak in the summer of 2017.[110] But for now, it appears that the Republicans in Congress have set aside large-scale "repeal and replace" bills.[111] This does not necessarily mean, however, that efforts to transform Medicaid have ended. Even in the absence of any attempt to eliminate the ACA's Medicaid expansion through the budget reconciliation process, we may see a push to per capita cap or block grant Medicaid either as stand-alone legislation or as part of other legislation.[112] Regularizing Medicaid funding and devolving federal control over the program have both been Republican goals for some time,[113] and it is entirely possible that these efforts will continue for the foreseeable future.

Efforts to rein in Medicaid spending are at least theoretically more pressing now that the Republicans successfully passed their tax overhaul in December 2017. The Congressional Budget Office ("CBO") estimates the new law will cost $1.4 trillion over the next decade.[114] Republicans were likely positioning themselves to make such cuts, as evidenced by the budget plan they passed in fall 2017, calling for $1.3 trillion in cuts to Medicaid and ACA subsidies over the next decade.[115] Rather than pursuing entitlement reform in the tax cut bill itself, House Speaker Paul Ryan and a number of the bill's

110. *See, e.g.*, Robert Pear & Thomas Kaplan, *Senate Health Care Bill Includes Deep Cuts to Medicaid*, N.Y. TIMES (June 22, 2017), https://www.nytimes.com/2017/06/22/us/politics/senate-health-care-bill.html.

111. *See* Lauren Fox, *John McCain Won't Back Graham-Cassidy Bill Likely Ending GOP Health Care Push*, CNN (Sept. 22, 2017, 4:45 PM), http://www.cnn.com/2017/09/22/politics/john-mccain-health-care/index.html [https://perma.cc/92VF-K3R8].

112. Robin Rudowitz, *5 Key Questions: Medicaid Block Grants & Per Capita Caps*, KAISER FAMILY FOUND. (Jan. 31, 2017), https://www.kff.org/medicaid/issue-brief/5-key-questions-medicaid-block-grants-per-capita-caps [https://perma.cc/9TCQ-C6BZ].

113. *See* Anna Maria Barry-Jester, *The GOP Has Been Trying to Change Medicaid Since Reagan*, FIVETHIRTYEIGHT (July 5, 2017, 10:14 AM), https://fivethirtyeight.com/features/the-gop-has-been-trying-to-change-medicaid-since-reagan [https://perma.cc/4EAP-72GM].

114. Letter from Keith Hall, Dir., Cong. Budget Office, to the Honorable Kevin Brady, Chairman, Comm. On Ways & Means (Dec. 15, 2017), https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/53415-hr1conferenceagreement.pdf [https://perma.cc/4EM4-WL73].

115. *Senate Budget Plan Threatens Health Priorities*, CTR. FOR BUDGET & POL'Y PRIORITIES (Nov. 9, 2017), https://www.cbpp.org/sites/default/files/atoms/files/10-18-17health-onesheet.pdf [https://perma.cc/56N8-XKF7].

other proponents suggested they would instead seek to cut spending on Medicaid, Medicare, and other programs in 2018.[116] The CBO estimated that the changes the Republicans proposed to Medicaid in the AHCA and the BCRA would have saved $839 billion[117] and $756 billion[118] over ten years, respectively. However, with the subsequent passage of a two-year budget deal in 2018, a razor-thin Republican majority in the Senate, and upcoming elections in November 2018, it is unlikely that that there will be a major push to contain Medicaid in the short term.[119]

116. Sarah O'Brien, *Advocates: Cost of GOP Tax Bill Puts Entitlement Programs at Risk of Cuts*, CNBC (Dec. 6, 2017, 10:20 AM), https://www.cnbc.com/2017/12/06/advocates-cost-of-gop-tax-bill-puts-entitlement-programs-at-risk-of-cuts.html [https:/perma.cc/5EL8-8JMA] ("[J]ust this week, House Majority Leader Kevin McCarthy signaled that changes to entitlement programs could help tackle the deficit. 'I worry about deficits, but you're not going to get out of this problem until you grow the economy,' McCarthy said Monday, on CNBC's 'Squawk Box.' 'Then, you've got to look at the entitlements,' he added."); Peter Weber, *GOP Senator Says Tax Cuts Must Be Followed by 'Structural Changes to Social Security and Medicare'*, THE WEEK (Nov. 30, 2017), http://theweek.com/speedreads/740454/gop-senator-says-tax-cuts-must-followed-by-structural-changes-social-security-medicare [https:// perma.cc/F8NF-FSGF] (quoting Republican Senator Marco Rubio: "I analyze this very differently than most . . . . Many argue that you can't cut taxes because it will drive up the deficit. But we have to do two things. We have to generate economic growth which generates revenue, while reducing spending. That will mean instituting structural changes to Social Security and Medicare for the future."); Nathaniel Weixel, *Ryan Eyes Push for 'Entitlement Reform' in 2018*, THE HILL (Dec. 6, 2017, 5:24 PM), http://thehill.com/homenews/house/363642-ryan-pledges-entitlement-reform-in-2018 [https://perma.cc/9C8L-XV8B] ("[H]ealth-care entitlements such as Medicare and Medicaid 'are the big drivers of debt,' Ryan said, 'so we spend more time on the health-care entitlements, because that's really where the problem lies, fiscally speaking.'").

117. CONG. BUDGET OFFICE, COST ESTIMATE: H.R. 1628, AMERICAN HEALTH CARE ACT OF 2017, at 3 (2017).

118. Letter from Keith Hall, Dir., CBO, to Mike Enzi, Chairman, Senate Comm. on the Budget, at 3 (July 20, 2017) (posted on the Website of the Senate Committee on the Budget), https://www.cbo.gov/system/files/115th-congress-2017-2018/Costestimate/52941-hr1628bcra.pdf [https://perma.cc/7W2B-6GMS] (regarding H.R. 1628, the Better Care Reconciliation Act of 2017: An Amendment in the Nature of a Substitute [ERN17500]).

119. On the more liberal end of the spectrum, Senator Schatz and Representative Lujan recently introduced legislation that would allow all Americans purchasing coverage through a state ACA exchange to buy into Medicaid, regardless of their income. *See* State Public Option Act, S. 2001, 115th Cong. (2017), https://www.congress.gov/bill/115th-congress/senate-bill/2001/text [https://perma.cc/BPL9-S8LV]; State Public Option Act, H.R. 4129, 115th Cong. (2017), https://www.congress.gov/bill/115th-congress/house-bill/4129/text [https://

Congress is not the only locus of potential changes to Medicaid. Even in the absence of congressional action, we will undoubtedly see changes at the state level through § 1115 waivers.[120] These waivers, made under § 1115 of the Social Security Act, allow states to seek federal permission to disregard one or more federal rules regarding Medicaid, in order to "test" how well a novel way of providing Medicaid benefits might work, and still get federal Medicaid matching funds for it.[121] To be granted, a demonstration proposal must meet a number of requirements, including being "likely to assist in promoting the objectives of subchapter . . . XIX of [Medicaid]."[122]

States have typically used § 1115 waivers to expand coverage to populations that would otherwise not be eligible for federal matching funds under Medicaid.[123] States also have used § 1115 waivers to require beneficiaries to use managed care programs rather than programs that allow beneficiaries unfettered choice of health care provider.[124] More recently, states have used § 1115 waivers to provide incentives for beneficiaries to use preventive care

perma.cc/KG4V-Q6VC]. In other words, it would use Medicaid as a "public plan option." The bill has little chance of moving forward in the short term but may offer a potentially fruitful possibility for the exchanges in the future.

120. *About Section 1115 Demonstrations*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html [https://perma.cc/F4NW-WYBU] (last visited July 31, 2018).

121. 42 U.S.C. § 1315(a) (2014).

122. *Id.* These objectives are to:

> enable each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.

42 U.S.C. § 1396-1 (2012).

123. *See, e.g.*, CTRS. FOR MEDICARE & MEDICAID SERVS., SPECIAL TERMS AND CONDITIONS: UTAH PRIMARY CARE NETWORK 1–5 (2010) (extending a demonstration project started in 2002 to expand eligibility for primary care services to certain impoverished, non-disabled, non-elderly adults).

124. *See, e.g.*, Dan Bogert, *AHCCCS Overview: A Brief History and Overview of County Nexus to the State-Run Medicaid Program* 2–4, http://www.countysupervisors.org/wp-content/uploads/2014/09/Healthcare-Overview-Final-_-No-CB.pdf [https://perma.cc/XA5M-RXQL] (last visited July 31, 2018) (discussing the history of Arizona's Health Care Cost Containment System).

services,[125] or to discourage arguably inappropriate use of the emergency room,[126] or even to provide private coverage for beneficiaries rather than more traditional Medicaid coverage.[127] Section 1115 gives states more choice in their Medicaid programs, to the extent they want that choice, but it also introduces more complexities into the program.[128]

The types of changes states successfully obtain have varied based in part on the ideological bent of the administration in office. Thus, for example, while punishments for failing to meet certain "personal responsibility" requirements were sometimes permitted under the George W. Bush Administration, the Obama Administration refused to grant waivers for similar provisions until near the end of his second term in office.[129]

Different administrations have varied in the explicitness of their § 1115 waiver criteria, as well. Under the Trump Administration, CMS now states it will judge waiver applications based on their ability to:

> (1) Improve access to high-quality, person-centered services that produce positive health outcomes for individuals;

125. *See, e.g.*, CTRS. MEDICARE & MEDICAID SERVS., SPECIAL TERMS AND CONDITIONS: HEALTHY INDIANA PLAN (HIP) 2.0, at 2 (2015), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf [https://perma.cc/K7 AN-N7PB] (stating that HIP beneficiaries who successfully complete certain preventive care services are eligible to roll over funds in their medical savings accounts from one year to the next).

126. *Id.* at 26 (discussing the $8 copayment that HIP beneficiaries who make non-emergent use of the emergency department must pay).

127. *See, e.g.*, CTRS. MEDICARE & MEDICAID SERVS., SPECIAL TERMS AND CONDITIONS: ARKANSAS HEALTH CARE INDEPENDENCE PROGRAM (PRIVATE OPTION) 2 (2014), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-demo-appvl-12312014.pdf [https://perma.cc/RV9X-GAGK] (outlining how the program will provide private coverage for Arkansas' Medicaid expansion population).

128. *See generally* Elizabeth Hinton et al., *Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers*, KAISER FAMILY FOUND. (Dec. 13, 2017), https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-the-current-landscape-of-approved-and-pending-waivers/ [https://perma.cc/5Y3C-KRHJ] (providing a current listing of § 1115 waivers and the general process).

129. *See, e.g.*, Laura Hermer, *What to Expect When You're Expecting…Welfare Reform-Style Section 1115 Medicaid Waivers*, 27 ANN. HEALTH L. 37, 44–45, 47 (2018).

(2) Promote efficiencies that ensure Medicaid's sustainability for beneficiaries over the long term;
(3) Support coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals;
(4) Strengthen beneficiary engagement in their personal healthcare plan, including incentive structures that promote responsible decision-making;
(5) Enhance alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition; and
(6) Advance innovative delivery system and payment models to strengthen provider network capacity and drive greater value for Medicaid.[130]

Some of these criteria prioritize delivery-system reform to improve care delivery and reduce costs. Others, however, assume Medicaid beneficiaries are needlessly impoverished and encourage beneficiaries to move out of poverty and government-sponsored benefit programs. Such encouragement could be useful, depending on how it is accomplished.

Some states focused more on punitive measures than positive encouragement. States have sought or are currently seeking lock-out periods for nonpayment of premiums or other compliance failures;[131] mandatory work requirements;[132] charges for missed

130. *About Section 1115 Demonstrations*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html [https://perma.cc/F4NW-WYBU] (last visited July 31, 2018).

131. Ctrs. Medicare & Medicaid Serv., No. 11-W-00296/5, Healthy Indiana Plan (HIP) 2.0 2 (2015), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf [https://perma.cc/K7AN-N7PB] [hereinafter HIP 2.0].

132. Ctrs. Medicare & Medicaid Serv., No. 11-W-00287/6, Arkansas Works Section 1115 Demonstration (2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-pa2.pdf [https://perma.cc/4C9H-RCSR]; Ind. Family & Social Servs. Admin., No. 11-W-00296/5, Amendment Request to Healthy Indiana Plan (HIP) Section 1115 Waiver Extension Application 4–5 (2017); Office of the Governor, Kentucky Health: Helping to Engage and Achieve Long Term Health 12 (2017); Me. Dep't of Health & Human Serv., 1115 Waiver Application 5–7 (2017) [hereinafter Maine Waiver Application], http://www.maine.gov/dhhs/oms/documents/Draft_MaineCare_1115_application.pdf [https://perma.cc/QGJ4-AUGB]; N.H. Dep't of Health & Human Servs. No 11-W-00298/1, Section 1115 Demonstration Amendment 9–10

appointments;[133] elimination of retroactive eligibility and/or hospital determinations of presumptive eligibility to "encourage timely enrollment";[134] extra charges for individuals with "health risk behaviors";[135] extra charges for non-emergent emergency department use;[136] beneficiary drug testing;[137] and time limits on Medicaid enrollment for certain populations.[138]

Many of these requirements derive from a notion that the poor people are poor because they do not know how to live their lives properly.[139] As such, they need to be shown using carrots and sticks

(2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-pa3.pdf [https://perma.cc/MLY3-9HRS]; Utah Dep't of Health, Utah 1115 PCN Demonstration Waiver Amendment #20 2–3 (2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-pa3.pdf [https://perma.cc/TFC2-L6XX]; Wis. Dep't of Health Serv., Section 1115 Demonstration Waiver Amendment Application 8–9 (2017), https://www.dhs.wisconsin.gov/badgercareplus/clawaiver-finalapp.pdf [https://perma.cc/X5G7-7TQH] [hereafter Wis. Waiver Amendment].

133. *See, e.g.*, Letter from Andrew Slavitt, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs., to Thomas Betlach, Dir., Arizona Health Care Cost Containment System 2–3 (2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-demo-ext-09302016.pdf [https://perma.cc/RXT4-CS8W] (refusing to grant Arizona's request to charge low-income beneficiaries for missed appointments).

134. *See, e.g.*, Letter from Andrew Slavitt, Acting Adm'r, Ctrs. Medicare & Medicaid Servs., to Nicholas A. Toumpas, Commissioner, N.H. Dep't of Health and Human Servs. (2015), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program /nh-health-protection-program-premium-assistance-appvl-amend-req-06232015.pdf [https://perma.cc/R4L5-DHWY] ("The demonstration includes a conditional waiver of retroactive coverage, with implementation of the waiver conditioned upon receipt of data demonstrating that the state's coverage system provides a seamless eligibility determination experience for the beneficiary that ensures that the beneficiary will not have periods of uninsurance.").

135. Wis. Waiver Amendment, *supra* note 132, at 9.

136. HIP 2.0, *supra* note 131; Maine Waiver Application, *supra* note 132, at 8–9; Utah 1115 PCN Demonstration Waiver Amendment #20, *supra* note 132, at 4–5; Wis. Waiver Amendment, *supra* note 132, at 5.

137. Wis. Waiver Amendment, *supra* note 132, at 11–12.

138. *Id.* at 10.

139. *See* Lawrence M. Mead, *The Rise of Paternalism*, THE NEW PATERNALISM: SUPERVISORY APPROACHES TO POVERTY 22 (1997) (noting that the "new paternalism," as Mead terms it, "attempts to fill in the deficits of income and skills that the poor suffer because of disadvantaged backgrounds" and noting that "the goal of policy is remove limits, whether inner or outer").

how to live in a way that will prevent them from dependency on public handouts.[140] This notion was used successfully in the effort to repeal the old cash welfare program, AFDC, as well as in more recent changes to the Supplemental Nutritional Assistance Program.[141] It now appears to be a guiding principle for the Trump administration's approach to most means-tested benefit programs, including Medicaid.[142]

Seema Verma, in remarks to the National Conference of State Legislatures, said that "[b]elieving that community engagement requirements [e.g., paid or volunteer work] do not support or promote the objectives of Medicaid is a tragic example of the soft bigotry of low expectations consistently espoused by the prior administration. Those days are over."[143] One of President Trump's executive orders claims that "the welfare system . . . traps" people in poverty, and that the role of the federal government "is to clear paths to self-sufficiency," and only to provide aid to "those who are truly in need."[144]

But cutting programs, or making them more onerous to participate in has not helped us reduce poverty.[145] Rather, we have

140. *Id.* at 24 ("Paternalism aims to provide the combination of aid and structure—what [Mead calls] help and hassle—that it seems the seriously poor need.").

141. *See, e.g.*, U.S. DEP'T OF AGRICULTURE, SUPPLEMENTAL NUTRITIONAL ASSISTANCE PROGRAM (SNAP): ABLE-BODIED ADULTS WITHOUT DEPENDENTS (ABAWDS) (Feb. 26, 2018), https://www.fns.usda.gov/snap/able-bodied-adults-without-dependents-abawds ("While SNAP is intended to ensure that no one in our land of plenty should fear going hungry, it also reflects the importance of work and responsibility. SNAP rules require all recipients meet work requirements unless they are exempt because of age or disability or another specific reason.").

142. Letter from Ctrs. for Medicare & Medicaid Servs., to State Medicaid Dir. (Jan. 11, 2018), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf [https://perma.cc/L4CH-GALT] ("Today, CMS is committing to support state demonstrations that require eligible adult beneficiaries to engage in work or community engagement activities (e.g., skills training, education, job search, caregiving, volunteer service) in order to determine whether those requirements assist beneficiaries in obtaining sustainable employment or other productive community engagement and whether sustained employment or other productive community engagement leads to improved health outcomes.").

143. *See* Remarks by Administrator Seema Verma, *supra* note 69.

144. Exec. Order No. 13828, 83 Fed. Reg. 15941 (Apr. 10, 2018).

145. Troy R. Bennett, *Cutting Programs to Help the Poor Doesn't Eliminate Poverty,* BANGOR DAILY NEWS (Sept. 12, 2017, 11:32 AM), http://bangordaily news.com/2017/09/12/opinion/cutting-programs-to-help-the-poor-doesnt-elimin ate-poverty/ [https://perma.cc/ZJZ6-KDHH].

succeeded in ameliorating—though certainly not ending—poverty when we have created or expanded income supports and benefits that help stabilize and support peoples' lives, such as food stamps, housing subsidies, and health care.[146] We can do everything possible to push working-age Americans to work, but recurrent recessions are a constant feature of the economy over time.[147] We all need secure safety nets. Virtually none of us is immune to economic peril.[148]

Social Security provides a clear example, not of the "soft bigotry of low expectations," but rather of what a program can do to make a true, positive difference for a population.[149] When Social Security was enacted, approximately half the elderly who were no longer employed lived in poverty.[150] As the program went into effect, the percentage of elderly who were impoverished dropped dramatically.[151] By the 1960s, only about ten percent of the elderly were impoverished—a rate that has remained constant to this day.[152]

We need strong, stable access to health care for all. At the very least, we need a strong, stable safety net. More of us are coming to realize, after so many millions of us newly obtained access to health care through the Affordable Care Act, that we need public solutions

146. *See, e.g.*, Arloc Sherman & Tazra Mitchell, *Economic Security Programs Help Low Income Children Succeed over Long Term, Many Studies Find*, CTR. ON BUDGET & POL'Y PRIORITIES (July 17, 2017), https://www.cbpp.org/sites/default/files/atoms/files/7-17-17pov.pdf [https://perma.cc/J9QD-466U] (finding that, while 26.3% of all Americans would have been impoverished in the absence of public assistance programs such as TANF, SNAP, and Medicaid, only 14.3% were once those programs were counted).

147. *See, e.g.*, Paul Krugman, *How Did Economists Get It So Wrong?*, N.Y. TIMES (Sept. 6, 2009), http://www.nytimes.com/2009/09/06/magazine/06Economic-t.html [https://perma.cc/V9G6-8CXD] (noting, regarding dealing with recessions, that "financial markets fall far short of perfection, that they are subject to extraordinary delusions and the madness of crowds").

148. *See, e.g.*, Quentin Fottrell, *Most Americans Have Less than $1,000 in Savings*, MARKETWATCH (Dec. 23, 2015), https://www.marketwatch.com/story/most-americans-have-less-than-1000-in-savings-2015-10-06 [https://perma.cc/J9J4-9L7G] (noting studies showing that over 60% of Americans have less than $1,000 in savings).

149. *See generally* Larry DeWitt, *The Development of Social Security in America*, 70 SOC. SECURITY BULL. (2010), https://www.ssa.gov/policy/docs/ssb/v70n3/v70n3p1.html [https://perma.cc/JZX3-EFPD].

150. *Id.* (noting that, while no national statistics were kept at the time on the poverty level of the elderly, a study of some state data from the period found the percentage "tended to cluster around the 50 percent level").

151. *Id.*

152. *Id.*

to this problem.[153] The voters of Maine, for example, decided to expand Medicaid via referendum after their governor repeatedly refused to expand the program.[154] Polling data since the 2016 election consistently show that American voters nationwide have realized we need the ACA, or some other regulatory system that performs similar functions.[155]

This is not to give up on personal responsibility—not at all. Most of the elderly poor in the 1930s were not derelicts who spent their adult, working lives frittering away their resources rather than saving them for retirement.[156] Rather, most supported themselves and their families during their working lives, but could no longer work and—like most Americans today—had not earned enough over their working lives to save adequately for retirement.[157] Again, around 50% of the elderly lived in poverty before Social Security was enacted.[158] That number would be similar today, if not for Social Security.[159]

153. Pew Research Center, *supra* note 59.

154. Christopher Cousins, *LePage Digs in for Medicaid Expansion Funding Battle*, BANGOR DAILY NEWS (Dec. 11, 2017), https://bangordailynews.com/2017/12/11/politics/lepage-digs-in-for-medicaid-expansion-funding-battle/ [https://perma.cc/TXS8-PYKL]. Governor LePage is seeking to prevent the referendum's mandate from taking effect. *Id.*

155. *See, e.g.*, Jennifer DePinto et al., *Poll: Most Disapprove of Graham-Cassidy Health Care Bill*, CBS NEWS (Sept. 25, 2017), https://www.cbsnews.com/news/poll-graham-cassidy-republican-health-care-bill-repeal-replace-obamacare-aca/ [https://perma.cc/9WGH-5JPU] (finding that only 20% approve of Graham-Cassidy, and that 87% of respondents believe private insurers should be required to insure individuals with pre-existing conditions); Hannah Fingerhut, *Support for 2010 Health Care Law Reaches New High*, PEW RES. CTR. (Feb. 23, 2017), http://www.pewresearch.org/fact-tank/2017/02/23/support-for-2010-health-care-law-reaches-new-high/ [https://perma.cc/7F27-R8BM] (finding that 54% of individuals polled supported the ACA).

156. *See* DeWitt, *supra* note 149 (explaining that, prior to the enactment of Social Security, most "nonworking elderly lived in some form of economic dependency, lacking sufficient income to be self-supporting").

157. *See id.* ("[F]ewer than 10 percent of workers in America had any kind of private pension plan through their work.").

158. *See id.* at fig. 4 ("Social Security has dramatically reduced poverty among the elderly.").

159. *See, e.g.*, *Policy Basics: Top Ten Facts about Social Security*, CTR. FOR BUDGET & POL'Y PRIORITIES, https://www.cbpp.org/research/social-security/policy-basics-top-ten-facts-about-social-security [https://perma.cc/3W6C-KT7D] (last visited July 31, 2018) (finding that approximately 40% of the elderly would live in poverty without Social Security, as compared to 9% today).

We live in a nation rather than in a state of nature for a reason—some things are better done together. We are stronger together. We can all insist on personal responsibility, but even the most responsible among us sometimes fall on hard times. We need Medicaid as a safety net for all.

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