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AN EMPIRICAL PERSPECTIVE ON MEDICAID AS SOCIAL INSURANCE

Nicole Huberfeld and Jessica L. Roberts***

INTRODUCTION

WHEN President Johnson signed Medicare and Medicaid into law in 1965, he saw those programs as essential components of his efforts to end poverty and racial inequities, a social project he dubbed the Great Society.¹ Almost 50 years after its enactment, Medicaid may at last achieve those ambitious goals. The central role Medicaid now plays in the American health insurance system is somewhat surprising. When the programs were enacted, Medicare took center stage, making Medicaid a “sleeper” program designed to care for America’s neediest—but not all of them.² For its first 49 years, Medicaid covered only about 40% of the nation’s poor.³ Today, one in five Americans have Medicaid coverage during the course of a year,⁴ and that number soon will increase to one in four given the insurance expansions enacted through the Patient Protection and Affordable Care Act (“the ACA”).⁵ The ACA is a fulcrum for Medicaid, shifting the old medical welfare program toward near-universal coverage. These numbers are the beginning of a story that reveals how the program now effectively functions as social insurance.

Medicaid’s status as social insurance is revealed through its prevalence in the historically covered, deserving poor as well as through its coverage of the newly eligible, many of whom are the working poor. This Essay will examine

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1. Lyndon Johnson’s “Great Society,” U.S. HISTORY ONLINE, <http://www.ushistory.org/us/56e.asp> (last visited Aug. 24, 2015).

2. Rosemary Stevens & Robert Stevens, *Medicaid: Anatomy of a Dilemma*, 35 LAW & CONTEMP. PROBS. 348, 348 (1971).

3. See, e.g., Randall R. Bovbjerg & William G. Kopit, *Coverage and Care for the Medically Indigent: Public and Private Options*, 19 IND. L. REV. 857, 861 (1986).

4. DEP’T OF HEALTH & HUMAN SERVS., MEDICAID & CHIP: APRIL 2014 MONTHLY APPLICATIONS, ELIGIBILITY DETERMINATIONS, AND ENROLLMENT REPORT 1, 3 (2014), available at <http://medicaid.gov/medicaid-chip-program-information/program-information/downloads/april-2014-enrollment-report.pdf>. See also JULIA PARADISE, HENRY J. KAISER FAMILY FOUND., MEDICAID MOVING FORWARD (2015), available at <http://files.kff.org/attachment/issue-brief-medicaid-moving-forward> (describing that more than one in five Americans were covered by Medicaid in December of 2014).

5. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

Medicaid beneficiaries through three measures. First is the percentage of the population of women and children that are covered and will be covered by Medicaid after the ACA. Second is the proportion of Medicaid funding that is spent on the elderly and the disabled and the degree to which Medicaid funds long-term care for both populations. Third is the early information about coverage of all non-elderly adults earning up to 138% of the federal poverty level (“FPL”), who thus far appear to comprise nearly half of all new insurance enrollees under the ACA’s federalized insurance coverage rules.

Though health care reform has never been an easy policy matter, Medicaid is often surprisingly under-philosophized when major health care changes occur. But, in its quotidian existence, especially during economic downturns, Medicaid has often been highly politicized. The latest iteration of this political theater surrounds Medicaid expansion. Some governors have attempted to buttress their anti-expansion arguments by proclaiming that government should refuse assistance to the “able bodied,” but their rhetoric rings hollow given how widespread employment is among the uninsured. For example, South Dakota Governor Dugaard initially rejected Medicaid expansion by explaining that “able-bodied” adults do not need access to such assistance because they are not disabled, and a Virginia legislator recently rejected Medicaid expansion because the “able-bodied” do not need “a new welfare entitlement.”⁶ However, whether to expand Medicaid is more than a question of the rhetoric in partisan politics.

This Essay begins to explore how Medicaid, after the ACA, metamorphoses from exclusion and limitations in access and benefits to a form of social insurance that implicates theories of social justice. The social justice aspect of universality provides an important lens for understanding these numbers, both in terms of the states that are expanding and the states that are opting out. States that refuse to expand their Medicaid programs are denying millions of Americans the benefit of a precious legal entitlement. It is essential that the states understand the power—and the potential—of this evolving social program and its newfound status as a vehicle of social insurance.

I. THE ACA’S FULCRUM

Medicaid has been mired in its history.⁷ The program began at the same time as Medicare, but little policy or political power was spent creating a

6. Jeffrey Young, *Dennis Dugaard, South Dakota Governor, Rejects Obamacare Medicaid Expansion*, HUFFINGTON POST (last updated Dec. 5, 2012, 5:26 PM EST), http://www.huffingtonpost.com/2012/12/05/dennis-dugaard-obamacare-rejects-medicaid_n_2244970.html. Governor Dugaard stated: “[T]hese are able-bodied adults. They’re not disabled; we already cover the disabled. They’re not children; we already cover children. These are adults -- all of them.” *Id.* See also Laura Vozzella, *Va. House GOP Budget Plan to Include Health Funds for Mentally Ill, Poor*, WASH. POST, Feb. 5, 2015, http://www.washingtonpost.com/local/virginia-politics/va-house-gop-budget-plan-to-include-health-funds-for-mentally-ill-poor/2015/02/05/84d14a0a-ad62-11e4-9c91-e9d2f9fde644_story.html.

7. Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 432 (2011) (demonstrating Medicaid’s path dependent history and federalist structure).

thoughtful safety net for the poor.⁸ Instead, political will was bent toward creating social insurance for the elderly, who successfully lobbied to be elevated into a national health insurance program—Medicare—and who were the more sympathetic population for most Americans.⁹ Medicaid offered generous federal funding to states and created a federal superstructure that states had to accept to receive that federal funding, but many decisions about who was eligible and how their medical care would be provided echoed old state medical welfare programs, and details were left to the states.¹⁰ This meant that the Elizabethan notion of the “deserving poor” was carried forward from colonial America into Medicaid,¹¹ and only a limited portion of the poor would receive medical welfare (aged, blind, disabled, pregnant women, some children). Also, limiting Medicaid to the deserving poor meant that “able-bodied” adults would never be eligible to enroll unless a state opted to spend its own money on undeserving poor citizens.¹² Thus, Medicaid was a safety net with many holes that isolated enrollees from the rest of the population, even though it was supposed to funnel the poor into mainstream medicine.

Over time, and often over state objections, the federal government incrementally increased the scope of federal standards for coverage and eligibility,¹³ requiring states to provide comprehensive medical coverage to children under age 21;¹⁴ expand coverage of the aged, blind, and disabled to comport with SSI’s federalization;¹⁵ expand eligibility for pregnant women and children;¹⁶ and support drug coverage for people enrolled in both Medicaid and Medicare.¹⁷ The ACA was another such step, arguably the biggest, requiring states to render eligible everyone under age 65 earning up to 133% of the FPL.¹⁸

The ACA jettisoned longstanding discrimination against non-elderly childless adults by making any poor citizen eligible to enroll in Medicaid, but that political choice has been constrained by the Supreme Court, at least for now.

8. *Id.* at 432-33. See also ROBERT STEVENS & ROSEMARY STEVENS, *WELFARE MEDICINE IN AMERICA* 53 (1974).

9. Huberfeld, *supra* note 7, at 436-38.

10. *Id.* at 441-42, 445-47.

11. *Id.* at 439-40 (providing the genesis of the deserving poor standard).

12. *Id.* at 440, 445-46.

13. See generally Nicole Huberfeld, Elizabeth Weeks Leonard & Kevin Outterson, *Plunging into Endless Difficulties: Medicaid and Coercion in National Federation of Independent Business v. Sebelius*, 93 B.U. L. REV. 1, 2-29 (2013) (explaining each of the Medicaid eligibility expansions).

14. Social Security Act Amendments of 1967, Pub. L. No. 90-248, 81 Stat. 821, 921-29 (codified in various sections of 42 U.S.C.).

15. Social Security Act Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329, 1370, 1465 (codified as amended in scattered sections of 42 U.S.C.).

16. Act of July 17, 1988, Pub. L. No. 100-360, 1988 U.S.C.C.A.N. (102 Stat.) 683.

17. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066.

18. See generally Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). The companion legislation to the ACA, the “HCERA,” effectively raised the eligibility level to 138% of FPL by creating a 5% income disregard. See Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

In *NFIB v. Sebelius*,¹⁹ the Court heard states' challenges to the ACA, which claimed (among other things) that the Medicaid expansion was so great a financial burden on the states, and such a change in the nature of the program, that it was unconstitutionally coercive.²⁰ Chief Justice Roberts's plurality held that the Medicaid expansion was a difference "in kind" rather than "in degree," despite prior such expansions by Congress of the Medicaid Act.²¹ Because the states could have lost all of their Medicaid funding for failing to expand eligibility to everyone under 133% of the FPL, not just the total funding for the expansion population, the plurality held that the expansion was an unconstitutional condition on federal spending because it crossed the line from inducement to coercion.²² Despite the unconstitutionality of the expansion, the Court did not strike down any aspect of the ACA or the Medicaid Act. Instead, it limited the Secretary of the Department of Health and Human Services's ("HHS") authority to withdraw funding from states that opted not to expand Medicaid eligibility.²³

Thus, the plurality in *NFIB* rendered the ACA's Medicaid expansion optional for states. While many states initially expressed reservations regarding the expansion, a greater number have opted in and many more continue to do so, primarily through negotiated waivers with the Secretary of the Department of Health and Human Services.²⁴ Regardless of the structural mechanism, Medicaid expansion is a new form of social insurance that is covering or will cover a wide swath of the population, many of whom are the working poor, which we discuss in the next section.

II. QUANTIFIED PERSPECTIVE ON MEDICAID COVERAGE

Health care in the United States is expensive relative to other first-world nations, and projections show costs continuing to rise.²⁵ Thus, while Americans rely on health insurance for access to needed medical care, prior to the ACA, almost one in five Americans were uninsured.²⁶ Historically, a majority of

19. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

20. *Id.* at 2601.

21. *Id.* at 2605.

22. *Id.* at 2603-04.

23. *Id.* at 2607.

24. See Tom Baker, Abbe R. Gluck, Nicole Huberfeld & Theodore Ruger, *The New Health Care Federalism: An Empirical and Theoretical Assessment of Federalism Dynamics in Health Care and Beyond* (Univ. Pa. Law Sch. Pub. Law Research Paper No. 14-34; Yale Law Sch. Pub. Law Research Paper No. 525, 2014), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2511003.

25. See generally Annie Lowery, *Health Care Spending's Recent Surge Stirs Unease*, N.Y. TIMES, Apr. 19, 2014, at B1, available at http://www.nytimes.com/2014/04/19/business/economy/health-care-spending-s-recent-surge-stirs-unease.html?_r=0.

26. RACHEL GARFIELD, RACHEL LICATA & KATHERINE YOUNG, KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE UNINSURED AT THE STARTING LINE: FINDINGS FROM THE 2013 KAISER SURVEY OF LOW-INCOME AMERICANS AND THE ACA, at ii (2015), available at <http://kff.org/uninsured/report/the-uninsured-at-the-starting-line-findings-from-the-2013-kaiser->

Americans have obtained health insurance as an employment benefit, and the ACA continues to charge employers with being the primary health insurance providers for non-elderly individuals.²⁷

Congress expanded Medicaid to capture those individuals who would remain uninsured even after the efforts to make employer-provided benefits more available.²⁸ As noted, pre-ACA Medicaid recipients conformed to the notion of the “deserving” poor; as written, the ACA eliminated these qualifying categories, rejecting old judgments regarding who is “deserving” of medical assistance and movement toward universal coverage.²⁹ Given the idiosyncrasies of the United States’ public/private hybrid health-insurance system, including continued reliance on employer-provided benefits and the exclusion of coverage for long-term care, a significant number of Americans will need the Medicaid program to access medically necessary health care.³⁰ Already, the program covers 20% of Americans in any given year.³¹ In light of the ACA, and considering the increasing cost of health care and the growing ability to prolong life in the face of old age and disability, this number will continue to rise. Early estimates put the number of newly eligible Americans at more than 18 million.³²

A substantial percentage of the pre-ACA uninsured came from working families whose employers do not offer them health insurance coverage or who do not offer affordable coverage.³³ About 63% of the uninsured population has at least one full-time worker in the family, and an additional 16% are employed in part-time jobs.³⁴ This means that approximately 79% of the uninsured have a

survey-of-low-income-americans-and-the-aca/ (asserting that nearly 18% of the population was uninsured prior to the ACA).

27. See Brendan S. Maher & Radha A. Pathak, *Enough About the Constitution: How States Can Regulate Health Insurance under the ACA*, 31 YALE L. & POL’Y REV. 275, 293 (2013); Kathryn L. Moore, *The Future of Employment-Based Health Insurance After the Patient Protection and Affordable Care Act*, 89 NEB. L. REV. 885, 886-87 (2011).

28. See Maher & Pathak, *supra* note 27, at 293.

29. Nicole Huberfeld & Jessica L. Roberts, *Medicaid Expansion as Completion of the Great Society*, 2014 U. ILL. L. REV. SLIP OPINIONS 1, 5, <http://www.illinoislawreview.org/wp-content/uploads/2014/11/Huberfeld.pdf>.

30. Samantha Artiga & Robin Rudowitz, *Medicaid Enrollment Under the Affordable Care Act: Understanding the Numbers*, HENRY J. KAISER FAMILY FOUND. (Jan. 29, 2014), <http://kff.org/health-reform/issue-brief/medicaid-enrollment-under-the-affordable-care-act-understanding-the-numbers/>.

31. KAISER COMM’N ON MEDICAID AND THE UNINSURED, MEDICAID: A PRIMER 1, 8 (2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf> [hereinafter MEDICAID: A PRIMER].

32. U.S. CONG. BUDGET OFFICE, THE BUDGET AND ECONOMIC OUTLOOK: 2014 to 2024, at 58 (2014), available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-Outlook2014_Feb.pdf (stating that by 2024, about 89 million people will be enrolled in Medicaid at some time during the year). See also Artiga & Rudowitz, *supra* note 30, at 1 n.2.

33. MELISSA MAJEROL, VANN NEWKIRK & RACHEL GARFIELD, KAISER COMM’N ON MEDICAID AND THE UNINSURED, THE UNINSURED: A PRIMER 4-5 (2015), available at <http://files.kff.org/attachment/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-in-america-primer>.

34. KAISER COMM’N ON MEDICAID AND THE UNINSURED, KEY FACTS ABOUT THE UNINSURED POPULATION 1, 4 (2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/>

family member in either a full-time or a part-time job that does not make health insurance benefits available, but 75% of the uninsured make less than 250% of the federal poverty level, and 38% are below 100% of the federal poverty level.³⁵ The early enrollment numbers in 2014 reflect the pervasiveness of Medicaid among the newly covered under the ACA: 49.4% of the newly insured were enrolled in Medicaid as of March 2014.³⁶ The new open enrollment may reveal different dynamics, but the number of employers offering health insurance benefits to low-income employees has not changed substantially.³⁷

Further complicating the employment benefit story, some observers have predicted that the ACA may hasten the death of the employer-provided benefits system, as employers could find paying the tax penalty (perhaps along with additional compensation to placate employees) a more cost-effective option than continuing to pay ever-increasing health insurance premiums.³⁸ Employers may drop insurance coverage as an employment benefit altogether, though early signs indicate that employer-based insurance benefits are holding steady.³⁹ However, ACA compliance is a new phenomenon, and in years to come, an increasing number of working Americans may find themselves depending on Medicaid.⁴⁰ Whether or not employers drop insurance coverage, Medicaid is the new employment benefit for the working poor, albeit a benefit that is government provided.

The low-income worker's need for Medicaid becomes even more pressing in the face of an economic downturn. When the number of available jobs

09/8488-key-facts-about-the-uninsured-population.pdf; RACHEL GARFIELD ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE COVERAGE GAP: UNINSURED POOR ADULTS IN STATES THAT DO NOT EXPAND MEDICAID—AN UPDATE, 1, 4 (2015), <http://files.kff.org/attachment/issue-brief-the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update>.

35. GARFIELD ET AL., *supra* note 34, at 4.

36. Adele Shartzter, Sharon K. Long & Stephen Zuckerman, *Who Are the Newly Insured as of Early March 2014?*, URBAN INST. (May 22, 2014), <http://hrms.urban.org/briefs/Who-Are-the-Newly-Insured.html>.

37. See KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS 38, 56-57 (2014), *available at* <http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report>.

38. MARK MERLIS, ACADEMYHEALTH, THE AFFORDABLE CARE ACT AND EMPLOYER-SPONSORED INSURANCE FOR WORKING AMERICANS I (2011), *available at* http://www.academyhealth.org/files/nhpc/2011/AH_2011AffordableCareReportFINAL3.pdf.

39. See Bruce Lee, *ACA's Broadened Eligibility Rules Have Little Impact on Employee Enrollment Levels in 2015*, MERCER (Mar. 17, 2015), <http://www.mercer.com/content/mercer/global/all/en/newsroom/aca-broadened-eligibility-rules-have-little-impact-on-employee-enrollment-levels-in-2015.html>. See also INT'L FOUND. OF EMP. BENEFIT PLANS, 2013 EMPLOYER-SPONSORED HEALTH CARE: ACA'S IMPACT, SURVEY RESULTS 4 (2013). At present the vast majority of employers have decided to continue offering coverage. *Id.* at 3. "The vast majority of organizations (94%) say they definitely or very likely will continue providing coverage when exchanges open in 2014, primarily to retain and attract talented employees. Fewer than 1% of all organizations say they definitely will discontinue coverage when exchanges open in 2014." *Id.* at 4.

40. Of course, some will obtain insurance through health insurance exchanges with tax subsidies, especially now that the Supreme Court held against the law's challengers in the *King v. Burwell* litigation, who argued that the federal government cannot offer tax subsidies in federally run exchanges. *King v. Burwell*, 135 S. Ct. 2480, 2496 (2015).

decreases, non-elderly Americans who would otherwise want to work will likely join the ranks of the unemployed. In 2014, approximately two job seekers existed for every open position.⁴¹ Put differently, no jobs are available for at least half of the population who want to work. Medicaid is essential for those individuals. In fact, for every percentage point increase in unemployment there is a corresponding one million-person increase in the number of Medicaid enrollees.⁴²

Pregnancy and childbirth provide another example of Medicaid's pervasive coverage, though this was true even before the ACA. From the payor's perspective, it is well known that prenatal care pays a lifetime of wellness benefits for both mother and child, and most states have long covered pregnant women at higher income levels than the Medicaid Act requires.⁴³ From a patient's perspective, for many women, pregnancy is a first encounter with consistent medical care, but non-pregnant and childless women have not been eligible for Medicaid until the ACA.⁴⁴

As of 2010, Medicaid already paid for a significant portion of the medical costs associated with births, and the program funded approximately 50% of American births.⁴⁵ Medicaid also covered more than half of "complex" births⁴⁶ and approximately two-thirds of unintended pregnancies.⁴⁷ The proportion of births covered by Medicaid in each state varies, with Louisiana leading at 70% of births.⁴⁸ Medicaid also provided 75% of the nation's publicly funded family planning services.⁴⁹

In addition, Medicaid has played a significant role for children, covering 37% of children, including newborns, as of 2012.⁵⁰ The ACA focused primarily on health insurance coverage for adults because states have covered children at income levels that are higher than the federal minimum required by the Medicaid

41. Heidi Shierholz, *Hires and Quits Were Flat in April, While Job Openings Rose*, ECON. POLICY INST. (June 10, 2014), <http://www.epi.org/publication/hires-quits-flat-april-job-openings-rose/>.

42. MEDICAID: A PRIMER, *supra* note 31, at 4.

43. Anne Rossier Markus et al., *Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform*, 23-5 WOMEN'S HEALTH ISSUES e273, e274 (2013), [http://www.whijournal.com/article/S1049-3867\(13\)00055-8/pdf](http://www.whijournal.com/article/S1049-3867(13)00055-8/pdf).

44. *Id.*

45. *Id.* at e273. See also Phil Galewitz, *Nearly Half of U.S. Births Are Covered by Medicaid, Study Finds*, KAISER HEALTH NEWS (Sept. 3, 2013), <http://capsules.kaiserhealthnews.org/index.php/2013/09/nearly-half-of-births-in-the-u-s-are-covered-by-medicaid-study-finds/>.

46. Markus et al., *supra* note 43, at e279 (noting complex births are more expensive than non-complex births).

47. GUTTMACHER INST., UNINTENDED PREGNANCY IN THE UNITED STATES 3 (2015), <http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.pdf>.

48. Markus et al., *supra* note 43, at e275.

49. *Publicly Funded Family Planning Services in the United States*, GUTTMACHER INST. (Oct. 2014), http://www.guttmacher.org/pubs/fb_contraceptive_serv.html.

50. ROBIN RUDOWITZ ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, CHILDREN'S HEALTH COVERAGE: MEDICAID, CHIP AND THE ACA 1, 4 (2014), available at http://kaiserfamilyfoundation.files.wordpress.com/2014/03/8570-children_s-health-coverage-medicaid-chip-and-the-aca1.pdf. See also Markus et al., *supra* note 43, at e273.

Act.⁵¹ Even so, the Medicaid Act bifurcated minors so that children ages 0-5 were eligible if their family earned 133% of the FPL or less, while children ages 5-18 were only covered up to 100% of the FPL.⁵² The ACA unified children's coverage so that all children up to age 18 will be eligible if their families earn up to 133% of the FPL.⁵³

Even in states that are not immediately expanding Medicaid eligibility—and despite the relatively generous expanded coverage many states have provided through either Medicaid or the Children's Health Insurance Program—more women and children will be covered because of the Medicaid expansion for at least three reasons. First, the ACA's "welcome mat" effect will facilitate enrollment of adults and children who were already eligible but not enrolled, including in states that have not yet opted into the Medicaid expansion. Second, in expansion states, non-pregnant and childless women who historically have been excluded from Medicaid coverage will now be covered and are likely to enroll. Thus, as soon as they become pregnant (which is likely to happen given that pregnancy will be unplanned for 51% of all women of reproductive age in the United States), these women will already be enrolled in Medicaid.⁵⁴ Not only will this increase the number of pregnancies covered, but also the pregnancies are likely to be healthier and to result in fewer pre-term or otherwise complex births.⁵⁵ Third, in the states that have expanded Medicaid, insured parents are more likely to have insured children, even when children would otherwise be eligible for Medicaid.⁵⁶ This is different from the welcome mat effect, because many parents were not impoverished enough to be on Medicaid, even if their children were, leading to under-enrollment of impoverished children due to parental non-enrollment. Now that parents are eligible up to 133% of the FPL, however, whole families will be covered who would have remained outside the system without expansion.

A substantial portion of the elderly also rely on Medicaid.⁵⁷ While Medicare covers many of the health-care costs for the over-65 population, that coverage is not comprehensive. Most glaringly, Medicare fails to cover most of the long-term care that becomes inevitable for many at the end of life.⁵⁸ Over 70% of the elderly population will require long-term care at some point in their

51. Markus et al., *supra* note 43, at e274.

52. *Id.*

53. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 § 2001 (2010).

54. UNINTENDED PREGNANCY IN THE UNITED STATES, *supra* note 47, at 2-3.

55. See Markus et al., *supra* note 43, at e279.

56. Ctr. on Budget & Policy Priorities & Georgetown Univ. Health Policy Inst., *Expanding Coverage for Parents Helps Children: Children's Groups Have a Key Role in Urging States to Move Forward and Expand Medicaid* (2012), available at <http://ccf.georgetown.edu/wp-content/uploads/2012/07/Expanding-Coverage-for-Parents.pdf>.

57. Paradise, *Medicaid Moving Forward*, *supra* note 4 (noting about 20% of Medicare beneficiaries are also enrolled in Medicaid).

58. MEDICAID: A PRIMER, *supra* note 31, at 4.

lives, though that care may be provided either in an institution or at home.⁵⁹ Of the 1,492,200 nursing home residents in the United States, 1,317,300 are over age 65,⁶⁰ or just over 88%. The numbers show that anyone who requires institutional long-term care (but lacks comprehensive long-term care insurance)⁶¹ will depend on Medicaid, which is the largest insurer of long-term care and covers 60% of long-term care residents⁶² and 40% of long-term care expenses.⁶³ Even individuals who have saved may find they cannot cover their full long-term care expenses over time, leading elderly Americans to engage in the notorious process of “spend[ing] down” to qualify.⁶⁴ At present the elderly make up approximately 59% of the population that is dually eligible for Medicare and Medicaid.⁶⁵ Thus, should long-term care costs continue to rise, more and more aging Americans will be unable to cover those expenses independently and will turn to Medicaid for assistance.

Non-elderly individuals with serious disabilities must also rely on Medicaid. Medicaid covers the health-care and long-term care expenses of 9.3

59. DONALD REDFOOT & WENDY FOX-GRAGE, AARP PUB. POL’Y INST., MEDICAID: A PROGRAM OF LAST RESORT FOR PEOPLE WHO NEED LONG-TERM SERVICES AND SUPPORTS 1 (2013), available at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2013/medicaid-last-resort-insight-AARP-ppi-health.pdf (stating that 7 out of 10 people turning 65 will need long-term care at some point in their lives).

60. CTR. FOR DISEASE CONTROL & PREVENTION, NATIONAL NURSING HOME SURVEY tbl.8 (rev. Nov. 5, 2010), available at [http://www.cdc.gov/nchs/data/nnhsd/Estimates/nnhs/Estimates_PaymentSource_Tables.pdf](http://www.cdc.gov/nchs/data/nnhhd/Estimates/nnhs/Estimates_PaymentSource_Tables.pdf) (2004 Current Resident Tables).

61. According to the AARP, between seven and nine million citizens had long-term care insurance as of 2010. KATHLEEN UJVARI, AARP PUB. POL’Y INST., LONG-TERM CARE INSURANCE: 2012 UPDATE 1 (2012). This number and the percentage of the elderly with long-term care insurance appear to have remained low over time, in part due to the Medicaid coverage available for long-term care once a person is impoverished. *Id.*; Paradise, *Medicaid Moving Forward*, *supra* note 4.

62. REDFOOT & FOX-GRAGE, *supra* note 59, at 1.

63. MEDICAID: A PRIMER, *supra* note 31, at 4.

64. See KAISER COMM’N ON MEDICAID & THE UNINSURED, THE MEDICAID MEDICALLY NEEDY PROGRAM: SPENDING AND ENROLLMENT UPDATE 2, 3 (2012), available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/4096.pdf>. The elderly make up about 25% of enrollees in the medically needy program. *Id.* at 10. The internet is replete with guides for the aging population explaining how to “spend down” and transfer assets so that they can qualify for Medicaid when they enter long-term care without a waiting period for Medicaid financing. See generally, e.g., ENID KASSNER & LEE SHIREY, MEDICAID FINANCIAL ELIGIBILITY FOR OLDER PEOPLE: STATE VARIATIONS IN ACCESS TO HOME AND COMMUNITY-BASED WAIVER AND NURSING HOME SERVICES (2000), available at http://assets.aarp.org/rgcenter/health/2000_06_medicaid.pdf; *Safe Ways to Spend Down Your Assets to Qualify for Medicaid*, NOLO, <http://www.nolo.com/legal-encyclopedia/safe-ways-spend-down-your-assets-qualify-medicaid.html> (last visited Aug. 24, 2015); *Medicaid and Spend Down Eligibility*, AGINGCARE.COM, <http://www.agingcare.com/medicaid-spend-down> (last visited Jan. 19, 2015); *Spending Down Assets to Qualify for Medicaid*, ELDERLAWANSWERS, <http://www.elderlawanswers.com/spending-down-assets-to-qualify-for-medicaid-12003> (last modified Jan. 30, 2015).

65. Of the 9.6 million dually eligible Americans, 5.7 million are over 65. KATHERINE YOUNG ET AL., KAISER COMM’N ON MEDICAID & THE UNINSURED, MEDICAID’S ROLE FOR DUAL ELIGIBLE BENEFICIARIES 1, 4 fig.1 (2013), available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/08/7846-04-medicaids-role-for-dual-eligible-beneficiaries.pdf>.

million non-elderly people with disabilities, including 1.5 million children.⁶⁶ In the past, individuals with severe disabilities such as cerebral palsy, Down syndrome, and autism were unable to obtain meaningful coverage in the private market.⁶⁷ Perhaps not surprisingly, then, Medicaid has historically been the “largest single source of health insurance and long-term care and the largest source of public financial support for people with disabilities.”⁶⁸ Hence, the program has been an essential element of health-care access for the disabled community. The ACA’s changes to Medicaid’s eligibility and enrollment rules further solidify Medicaid’s central role by accelerating the enrollment process for people with disabilities and improving the benefits packages available.⁶⁹

In sum, despite negative political depictions,⁷⁰ as well as negative stereotypes frequently associated with Medicaid,⁷¹ many Americans—through no fault of their own—will require government assistance to pay for needed health care at some point in their lives. Because so many rely on Medicaid to access health care at so many junctures from birth to the end of life—including while working at a job that fails to offer benefits, during pregnancy, upon acquiring a disability, and throughout old age—Medicaid is no longer a limited program that touches only the “others” embodied in the sticky concept of the “deserving poor.” These statistics demonstrate that Medicaid now functions as a universal health insurance program to buttress those who are in need of health care but cannot afford it. With the ever-increasing cost of health care, that is a substantial portion of Americans.⁷² Medicaid is morphing into a form of social insurance.

66. MEDICAID: A PRIMER, *supra* note 31, at 10.

67. *Id.*

68. NAT’L COUNCIL ON DISABILITY, THE CURRENT STATE OF HEALTH CARE FOR PEOPLE WITH DISABILITIES 110 (2009) (quoting *Helping Families with Needed Care: Medicaid’s Role for People with Disabilities: Testimony Before the H. Comm. on Energy and Commerce Subcomm. on Health* 110th Cong. 22 (2008) (testimony of Diane Rowland)).

69. MARYBETH MUSUMECI, KAISER COMM’N ON MEDICAID & THE UNINSURED, THE AFFORDABLE CARE ACT’S IMPACT ON MEDICAID ELIGIBILITY, ENROLLMENT, AND BENEFITS FOR PEOPLE WITH DISABILITIES 1, 12 (2014), available at <https://kaiserfamilyfoundation.files.wordpress.com/2014/04/8390-02-the-affordable-care-acts-impact-on-medicaid-eligibility.pdf>.

70. See, e.g., Sydney Brownstone, *13 Governors Screwing Over the Uninsured*, MOTHER JONES (Feb. 20, 2013, 7:01 AM EST), <http://www.motherjones.com/mojo/2013/02/meet-governors-rejecting-expansion-medicaid>.

71. See, e.g., Heidi Allen et al., *The Role of Stigma in Access to Health Care for the Poor*, 92 MILBANK Q. 289 (2014); Jennifer Stuber & Karl Kronebusch, *Stigma and Other Determinants of Participation in TANF and Medicaid*, 23 J. POL’Y ANALYSIS & MGMT. 509 (2004); Jennifer Stuber & Mark Schlesinger, *Sources of Stigma for Means-Tested Government Programs*, 63 SOC. SCI. & MED. 933 (2006).

72. One in three Americans are below the poverty line. Brad Plumer, *One in Three Americans Slipped Below the Poverty Line Between 2009 and 2011*, WASH. POST. WONKBLOG (Jan. 8, 2014), <http://www.washingtonpost.com/blogs/wonkblog/wp/2014/01/08/one-in-three-americans-slipped-below-the-poverty-line-between-2009-and-2011/>.

III. MEDICAID AS SOCIAL INSURANCE

The numbers described in the preceding part demonstrate how Medicaid has grown through its first 49 years and its potential to touch the lives of even more Americans in the coming years. More and more people will likely find themselves relying on the program at some point in their lives. This ever-increasing reliance, coupled with the efforts of lawmakers to extend the program to even more beneficiaries, raises Medicaid to the level of social insurance.

Social insurance can be defined as a “public insurance program that provides protection against various economic risks (e.g., loss of income due to sickness, old age, or unemployment) and in which participation is compulsory.”⁷³ In the United States, the connotation for social insurance is narrower, focusing on the original form of American social insurance: Social Security. As the best-known example of this kind of benefit, the terms “social security” and “social insurance” have been used interchangeably.⁷⁴ Social Security is a form of saving afforded to workers, and according to the National Academy of Social Insurance, social insurance is deemed social insurance in part because it is “financed by workers and employers.”⁷⁵ This linkage indicates how closely tied social insurance and work have been in the United States. However, this Essay asserts that the changes to the Medicaid program over time and the growing percentages of Americans who rely on it to access health care render Medicaid a *de facto* social insurance program. Much like Social Security and Medicare, Medicaid provides some protection against the economic insecurities of medical care for people of all ages. Tying social insurance to work is uniquely American and is wrapped up in the old notions of worthiness (and blameworthiness).

To be sure, at its inception, Medicaid was far from being a social insurance program. As discussed, it provided benefits to a small number of very specific enrollees deemed worthy of public assistance.⁷⁶ However, even then the program was an entitlement: Anyone who was eligible under the Medicaid Act at a given point in time had to be enrolled in the program.⁷⁷ Moreover, states could not delay applicants’ admittance into Medicaid, deny their applications, or otherwise cap enrollment.⁷⁸ These essential aspects rendered Medicaid a legally enforceable entitlement for those impoverished Americans.⁷⁹

But what has made Medicaid transition from a statutory entitlement to social insurance? Social insurance differs from private insurance in certain key ways. Contributions are mandatory and benefits are not based solely on

73. *Social Insurance*, ENCYCLOPÆDIA BRITANNICA, <http://www.britannica.com/topic/social-insurance> (last visited Aug. 24, 2015).

74. *Id.*

75. *Learn*, NAT’L ACAD. SOC. INS., <http://www.nasi.org/learn> (last visited Aug. 24, 2015).

76. *See supra* Part I.

77. 42 U.S.C. § 1396a(a)(10) (2012).

78. *See id.*

79. Medicaid is also an entitlement for states; so long as they meet the terms of the Medicaid Act, the federal government must match the funds they spend on Medicaid by at least 50% and often more. For the Medicaid expansion, that amount is initially 100%. 42 U.S.C. § 1396a(a)(3) (2012); 42 C.F.R. §§ 431.151-154, 431.200-245 (2013).

contributions.⁸⁰ In the sense that Medicaid is publicly funded through tax dollars, arguably we all contribute to its existence. Moreover, Medicaid beneficiaries' entitlements are based on need, not on the degree to which they have paid in, which is also true for Medicare (one must pay a small percentage of income for 40 quarters, but the amount of the contribution does not influence Medicare coverage for any beneficiary).⁸¹ However, scholars have maintained that these attributes alone do not make Medicaid a program of social insurance. For example, Judy Feder has asserted that, given its eligibility criteria, "[r]ather than protecting people and their families from catastrophe, Medicaid provides support only after catastrophe strikes."⁸² Feder concludes that "[t]o effectively spread risk and reach the broadest possible population, public social insurance must be at the core of future policy."⁸³ However, this assessment fails to acknowledge Medicaid's movement toward universal eligibility.⁸⁴ As the criteria for eligibility expand and more Americans become eligible, Medicaid looks less like a narrow statutory entitlement for a restrictive set of worthy populations and more like a program of social insurance designed to help all Americans access health care—a true safety net, much like Medicare is for the elderly and disabled populations.

To that end, the expansion of Medicaid under the ACA is a social justice matter, not just an economic or political issue. Congress intended the ACA to significantly reduce the number of uninsured Americans to open the gateway to health care.⁸⁵ Positioning Medicaid as a catchall for lower income individuals in need of health insurance was among the primary mechanisms for achieving this goal.⁸⁶ Hence, when the Supreme Court made Medicaid expansion optional for states, it eroded the ACA's primary purpose. To dismiss Medicaid expansion as a political issue subject to the whims of inconsistent judicial notions of federalism ignores the social justice implications of the decision not to expand the program and disregards those individuals who will be unable to access health care as a result.

80. *Social Insurance*, *supra* note 73.

81. 42 U.S.C. §§ 402, 1395c, & 1395i-2. See also *Navigating Medicare and Medicaid: Medicaid*, HENRY J. KAISER FAMILY FOUND., <http://kff.org/other/navigating-medicare-and-medicare-online-version/> (last visited Aug. 24, 2015).

82. Judy Feder, *Social Insurance Is Missing a Piece: Medicare, Medicaid, and Long-term Care*, HEALTH AFFAIRS BLOG (Nov. 6, 2014), <http://healthaffairs.org/blog/2014/11/06/social-insurance-is-missing-a-piece-medicare-medicare-and-long-term-care/>.

83. *Id.*

84. "Near universal" because undocumented immigrants are not eligible for any form of public insurance in the United States, unless a person is treated in the emergency department, in which case Medicaid will reimburse the hospital for the treatment provided (but enrollment in Medicaid does not follow the care). 42 U.S.C. § 1396b(v) (2012).

85. *Key Facts About the Uninsured Population*, HENRY J. KAISER FAMILY FOUND. (Oct. 29, 2014), <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

86. *Id.* (explaining that "[d]ecreasing the number of uninsured is a key goal of the Affordable Care Act (ACA), which provides Medicaid coverage to many low-income individuals in states that expand and Marketplace subsidies for individuals below 400% of the poverty line").

Most states are moving toward Medicaid expansion, having already expanded eligibility or negotiating waivers with HHS.⁸⁷ But, certain states are refusing Medicaid expansion due to political opposition to the ACA of either the governor, the legislature, or both.⁸⁸ This resistance to expansion is occurring primarily in the deep South, where the numbers of uninsured and per capita poverty are concentrated.⁸⁹ Some governors have couched their resistance in terms of economic concerns, and some have questioned the federal government's intent to fully fund the expansion as promised in the ACA.⁹⁰ Whatever the reasoning, the result is that large swaths of the uninsured are concretely and negatively affected by non-expansion. Medicaid's new universality should protect these socially vulnerable populations, such as minimum wage workers, people of color, and people with disabilities, who are less likely to have health insurance and are less likely to have the means to pay for care out of pocket. But, these populations are disproportionately represented in holdout states.⁹¹

In the states where Medicaid expansion does not move forward this year, many of the penultimate poor will fall into a coverage gap that is a unique creation of the ACA and the holding in *NFIB* that rendered the expansion optional.⁹² People earning more than 100% of the FPL will be able to obtain private insurance through health insurance exchanges with the benefit of federal tax credits, but people earning less than 100% of the FPL will be ineligible for tax credits and will find that they are unable to obtain affordable health insurance.⁹³ Though they will not be penalized under the ACA, they are being denied an important statutory benefit that looks very much like other forms of social insurance in the United States.

87. See generally Nicole Huberfeld, *Dynamic Expansion* (Nov. 22, 2013) (unpublished working paper), available at <http://ssrn.com/abstract=2358641>.

88. Joshua Holland, *Study Shows the Madness of States Refusing to Expand Medicaid*, MOYERS & COMPANY (Aug. 14, 2014), <http://billmoyers.com/2014/08/14/study-shows-the-madness-of-states-refusing-to-expand-medicaid/>.

89. See HENRY J. KAISER FAMILY FOUND., *THE IMPACT OF THE COVERAGE GAP IN STATES NOT EXPANDING MEDICAID BY RACE AND ETHNICITY* 4 (2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/12/8527-the-impact-of-the-coverage-gap-in-states-not-expanding-medicaid.pdf>.

90. See, e.g., Jason Millman, *Another Argument Against the Medicaid Expansion Just Got Weaker*, WASH. POST WONKBLOG (Aug. 11, 2014), <http://www.washingtonpost.com/blogs/wonkblog/wp/2014/08/11/another-argument-against-the-medicaid-expansion-just-got-weaker/>.

91. A recent report deconstructs this characterization as the result of more than just racist politics by describing the past political choices states made in their Medicaid coverage; in the South, most states have limited Medicaid coverage due primarily to lack of funds, according to this report. See CHRISTOPHER PLEIN, ROCKEFELLER INST., *A TURBULENT OPPOSITION: THE ACA AND THE SOUTH* 9 (2014), available at [http://op.bna.com/hl.nsf/id/nwel-9nbrmt4/\\$File/2014-08-Southern_States_Overview.pdf](http://op.bna.com/hl.nsf/id/nwel-9nbrmt4/$File/2014-08-Southern_States_Overview.pdf).

92. See *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2607 (2012).

93. See *Explaining Health Care Reform: Questions About Health Insurance Subsidies*, HENRY J. KAISER FAMILY FOUND. 2-3 (2014), <http://kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/>.

CONCLUSION

Despite its humble origins, the Medicaid program has grown substantially and will continue to do so for the foreseeable future. It has morphed from a limited welfare program to near universal health care benefit for millions of Americans across their life spans. Because so many of the newly insured are low-income workers, Medicaid is beginning to look like social insurance. And, given its ubiquity, Medicaid can now be understood as social insurance. Meaningful access to affordable health care is an essential element to citizenship, and the newly universalized Medicaid program is a crucial aspect to ensuring that all Americans can obtain medical treatment when they need it and at all stages of life, from birth to death.