# The Irreplaceable Program in an Era of Uncertainty

*Sara Rosenbaum and Elizabeth Taylor*

As it has twice before in its 53-year history — in 1981 and 1995 — in 2017 Medicaid faced a near-death federal legislative experience spanning most of the year. Like before, a policy Armageddon generated a phenomenal response: fantastic advocacy outpouring at both the national policy and grassroots levels; enormous press coverage about Medicaid's unique role in the American health care system; numerous polls measuring the public's perception of Medicaid and the program's importance in everyday life.

Actually this is not surprising for a program that insured an estimated 73.5 million people in 2017[1] — roughly one in five Americans. What is surprising is that even in 1981 — when Medicaid covered 19.6 million children and adults (about a quarter of the enrollment level) and accounted for slightly more than $25 billion in spending (less than 5 percent of total projected spending in 2017)[2] — the Reagan Administration ran aground in its effort to repeal the program as a legal entitlement and replace it with a block grant.[3] Fourteen years later, in 1995,[4] an even harsher block grant proposal from Congressional Republicans[5] met a similar fate.[6] At the time of President Clinton's veto, Medicaid reached 33.4 million people — slightly more than 45 percent of projected 2017 enrollment; total expenditures that year stood at about one third their estimated 2017 levels.[7]

As a leading Medicaid policy thinker once put it, "there's something about Medicaid."[8] Even when Medicaid was relatively modest in size — before the breakthrough coverage reforms for children and pregnant women of the 1980s; before the 1996 reforms permitting expanded coverage of low income working parents; before evolving into the nation's largest funder of community-based long term services and supports; before it became the largest public health first responder in the wake of population disasters both natural and man-made; and long before the Affordable Care Act's seminal restructuring, which transformed it into full-blown public insurance for the poor[9] — its thoroughly unique qualities were evident.

After a somewhat modest start in terms of total enrollment, Medicaid consistently emerged as the most practical and effective program to address the health care needs of low-income people. Even in the case of working-age low-income adults and their families, the private insurance market never generated a lot of interest; indeed, over the years, insurers became enthusias-

**Sara Rosenbaum, J.D.**, *is the Harold and Jane Hirsh Professor of Health Law & Policy at the Milken Institute School of Public Health, The George Washington University.* **Elizabeth Taylor, J.D.,** *is the Executive Director of the National Health Law Program.*



*The Journal of Law, Medicine & Ethics*, 46 (2018): 883-886. © 2018 The Author(s)
DOI: 10.1177/1073110518821984
https://doi.org/10.1177/1073110518821984 Published online by Cambridge University Press

tic supporters of Medicaid expansion, including under the ACA.[10] The best explanation for the industry's willingness to forgo a large piece of the potential market for private coverage is its understanding regarding the need for a funding approach that hews to social welfare principles rather than premium-based financing. Similarly, Medicaid, rather than Medicare, became the financing vehicle of choice for everything from premium and cost-sharing affordability to long term services and supports, because Medicare relies so heavily on politically sensitive dedicated funding — a regressive payroll tax that affects the lowest-paid workers most heavily. This legislative approach effectively made Medicare financing out of the question as a means of resolving services and supports to beneficiaries who — by virtue of poverty, poor health, and other factors — need more than Medicare covers.

Its inherent funding elasticity — unencumbered by reliance either on a dedicated funding structure or individual premium payments — means that Medicaid has been able to grow when necessary, albeit with periodic political eruptions of the type that unfolded in 2017. The past half century of Medicaid reform could fill many books and has.

The fact that Medicaid rests on a general federal revenue base means that it has been able to be nimble over the years. As public health needs arose, Medicaid was scaled through expansions to meet these problems, a prime example of which was the child health reforms that took place between 1984 and 1990.[11] And of course, throughout its life, Medicaid has grown simply because it is structured as an open-ended entitlement to the states; this elasticity means that total Medicaid spending increased as a result of rising medical costs and as states refashioned their programs to meet local health needs, such as during recessionary periods[12] or, as the principal response to the opioid crisis that grips the nation and has left so many thousands of people in need of health care in its wake.[13] At the same time, however, even as they have increasingly used Medicaid to carry out multiple efforts to improve population health, states have a natural inclination to constrain program size, because their financial stake in Medicaid is substantial.[14] Enrollment accounts for 70 percent of Medicaid growth over time, but states constrain Medicaid through constraints on provider payment, heavy use of spending controls such as Medicaid managed care (which accounts for 75 percent of all beneficiaries),[15] and limits on eligibility and coverage.

Its inherent funding elasticity — unencumbered by reliance either on a dedicated funding structure or individual premium payments — means that Medicaid has been able to grow when necessary, albeit with periodic political eruptions of the type that unfolded in 2017. The past half century of Medicaid reform could fill many books and has. A few examples provide a flavor.

In 1967, when early studies showed the major physical, dental, developmental, and mental health risks that confronted the poorest children and adolescents, Congress amended the statute to cover early and periodic screening, diagnosis and treatment (EPSDT), a level of pediatric coverage that has no statutory rival either in private insurance market or the much-later Children's Health Insurance Program (CHIP).[16] When it became evident that the employer insurance system left out children living in low-income working families (who either had no workplace coverage or could not afford what was available), Congress gradually extended Medicaid to all children in need; today 40 percent of U.S. children rely on Medicaid and its smaller CHIP companion.[17] When inadequate prenatal care for poor women became subject of focus, along with elevated national infant mortality rates, Medicaid responded through amendments to expand coverage of low income pregnant women regardless of their family living arrangements; the program now pays for nearly half of all U.S. births.[18] When it became clear that the nation could not, without greater social investment, fulfill the promise of equal opportunity for people with disabilities at risk of discriminatory segregation and isolation through unnecessary institutionalization, Medicaid was reconfigured to carry out this mission.[19] When it became evident that supplemental and enhanced financing was needed to anchor health care providers in high poverty-communities heavily dependent on Medicaid, the program was restructured to provide enhanced funding for clinics[20] and hospitals[21] that disproportionately serve these populations.

In 2017 opponents of entitlement spending on the poor and of significant federal policy and financial commitment to their health and welfare attacked Medicaid ferociously over its size, mission, and financing structure. Ironically, these attacks tended — as they have before — simply to once again bring the responsibilities Medicaid shoulders into sharper focus as a result of



*The Journal of Law, Medicine & Ethics*, 46 (2018): 883-886. © 2018 The Author(s)

https://doi.org/10.1177/1073110518821984 Published online by Cambridge University Press

extensive news coverage and advocacy. Public opinion responded, and in the end, so did policymakers. People were struck by the enormity of Medicaid's many missions, perhaps mostly strongly so where its dominant role in long-term care for children and adults is concerned. [22] Similarly striking to many was the program's relatively low cost on a comparative per-capita basis; indeed, it became clear that given what it is asked to do, and compared to private insurance, Medicaid is a bargain.[23] The evidence of Medicaid's ability to virtually equalize access to care for those it insures [24] also rose to the forefront of policy communication.

The repeal fight of 2017 saw Medicaid repeatedly savaged for its alleged inflexibility; indeed, inflexibility became code for savaging a statutory structure that, to be sure imposes enormous requirements on participating states but also provides open-ended entitlement funding. The quid pro quo for flexibility — in the form of new state options to reduce eligibility and benefits, impose work requirements, and exclude Planned Parenthood as a participating Medicaid provider[25] — was enormous cuts in funding through arbitrary limits on federal payments. Had they been enacted, the massive funding reduction envisioned by opponents essentially would have meant that the federal government was walking away from its half-century commitment to supporting states' historic role and leadership in delivering and funding health care for the poor as a basic aspect of their constitutional police powers.

To be sure, Medicaid demands that participating states meet a host of federal requirements. But for a program projected to spend roughly $5 trillion in federal financing between FY 2016 and FY 2025,[26] its rules are pretty mild and afford states considerable autonomy — reinforced by the United States Supreme Court in *National Federation of Independent Businesses v. Sebelius* — over whom and what they cover. The legislative structure also gives states flexibility over how they organize, regulate, and pay for care and the types of cost-containment strategies they use. By any measure, the deal states get in return is impressive — an open-ended federal legal entitlement to generous financing (between 50 and 75 cents on the dollar in 2018, considerably more for the ACA expansion population) for the cost of medically necessary care they pay for. It is this reality that explains why despite the rhetoric, the ranks of Republican Governors contained sizable opposition to deep cuts to Medicaid as a President and a Congressional majority — eager to find $1 trillion to pay for tax cuts for the wealthy — sought to renege on a 50-year-old deal. [27]

In the coming years, there likely will be more existential face-offs like those that already have occurred. Medicaid truly is immense, and even though its per-capita payments are well below what the same care would cost in the private insurance market,[28] the federal/state partnership for insuring the poor and vulnerable demands continuous commitment to improved cost-efficiencies that can safely be achieved without sacrificing quality and effectiveness. To this end, the Obama Administration embarked on a major modernization effort aimed at moving the full Medicaid population into organized delivery arrangements driven by all-inclusive rates in order to encourage the most efficient use of resources.[29] Similarly, federal policymakers increasingly are eying such big-ticket items as prescribed drug purchasing for further reform.[30]

What obviously is not a path forward is to abandon the people who depend on Medicaid and the states as they struggle with the complexities of insuring the poor and high-health-risk population. To this end, the Trump Administration's full-on political attack on Medicaid eligibility for working-age adults through the imposition of work requirements — unlawfully attempted, and grossly mischaracterized as Social Security Act-sanctioned research to improve the health of the poor[31] — promises to be a defining chapter in the battle over Medicaid's future. As of June 2018, a federal court had enjoined the Trump Administration's sanctioned work demonstration in Kentucky as arbitrary and capricious because of its complete failure to consider the impact of the demonstration on Medicaid's core objective, to insure the poor.[32] More court challenges to the Administration's thinly disguised effort to effectuate a large-scale disenrollment of low income adults may be in the offing. One can only hope that these challenges continue to succeed; the American health care system itself relies on Medicaid's future stability, and its record of achievement more than justifies the trust that the public has placed in the program as an irreplaceable part of the U.S. health care system.

## Note

The authors have no conflicts to disclose.

## References

1. United States Department of Health and Human Services, 2016 Actuarial Report on the Financial Outlook for Medicaid, Table 3 (2016), *available at* <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf> (last visited October 24, 2018).
2. United States Department of Health and Human Services, *2016 Actuarial Report on the Financial Outlook for Medicaid*, Table 3 (2016), *available at* <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf> (last visited October 26, 2018).
3. D. Smith and J. Moore, *Medicaid Politics and Policy*, 2d ed. (New York: Transaction Publishers, 2015): 117-133.



*The Journal of Law, Medicine & Ethics,* 46 (2018): 883-886. © 2018 The Author(s)

https://doi.org/10.1177/1073110518821984 Published online by Cambridge University Press

4. R. Pear, "Republicans Want to Give States Vast New Powers Over Medicaid," *New York Times*, April 1, 1995, *available at* <https://timesmachine.nytimes.com/timesmachine/1995/04/01/978095.html?action=click&contentCollection=Archives&module=LedeAsset&region=ArchiveBody&pgtype=article&pageNumber=1> (last visited October 26, 2018).
5. S. Rosenbaum, S. Schmucker, S. Rothenberg, and R. Gunsalus, "What Would Block Grants or Limits on Per Capita Spending Mean for Medicaid?" (New York, Commonwealth Fund, 2016) *available at* <http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2016/nov/1913_rosenbaum_medicaid_block_grants.pdf> (last visited October 26, 2018).
6. *Id*., at 181-224; see also, R. Pear, "Republicans Want to Give States Vast New Powers Over Medicaid," *New York Times*, April 1, 1995 *available at* <https://timesmachine.nytimes.com/timesmachine/1995/04/01/978095.html?action=click&contentCollection=Archives&module=LedeAsset&region=ArchiveBody&pgtype=article&pageNumber=1> (last visited October 26, 2018).
7. Actuarial Report, *supra* note 2.
8. A. Weil, "There's Something About Medicaid," *Health Affairs* 14 (2003): 22.
9. The Chief Justice may have been wrong on the law when, in *National Federation of Independent Businesses v. Sebelius*, 132 S. Ct. 2566 (2012) he declared the ACA insurance reforms a "new program" in his analysis of the constitutionality of the Medicaid expansion. But he certainly was correct as a matter of policy in recognizing the ACA Medicaid expansion as a "shift in kind, not merely degree," an amendment that transformed a "program to care for the neediest among us" into an "element of a comprehensive national plan to provide universal health insurance coverage." See 132 S. Ct. 2566, at 2605-2606.
10. The Medicaid managed care market is vast, but it is a market in which plans are structured to share risk with states, not absorb it entirely, and many of the costliest services get carved out of plan contracts. This helps explain the enthusiasm.
11. S. Rosenbaum, *Medicaid at Fifty* (New York: Oxford University Press, 2018).
12. This of course helps explain the great tension between the federal and state governments where Medicaid policy is concerned, since as a general matter state operating budgets are expected to adhere to some level of budget-balancing requirement, although the strength of these requirements varies considerably. See National Conference of State Legislatures, *State Balanced Budget Provisions* (2010) *available at* <http://www.ncsl.org/documents/fiscal/StateBalancedBudgetProvisions2010.pdf> (last visited October 26, 2018).
13. Medicaid and CHIP Payment and Access Commission (MACPAC), *Medicaid and the Opioid Crisis* (July 2017), *available at* <https://www.macpac.gov/wp-content/uploads/2017/06/Medicaid-and-the-Opioid-Epidemic.pdf> (last visited October 26, 2018).
14. L. Clemens-Cope et al., *Medicaid Spending Growth Compared to Other Payers: A Look at the Evidence* (Kaiser Family Foundation, 2016), *available at* <https://www.kff.org/medicaid/issue-brief/medicaid-spending-growth-compared-to-other-payers-a-look-at-the-evidence/> (last visited October 26, 2018).
15. Medicaid and CHIP Payment and Access Commission, *Managed Care Overview*, *available at* <https://www.macpac.gov/subtopic/managed-care-overview/> (last visited October 26, 2018).
16. S. Rosenbaum and P. Wise, "Crossing the Medicaid/Private Insurance Divide: The Case of EPSDT," *Health Affairs* 382, no. 26 (2007): 383-384.
17. Kaiser Family Foundation, *State Health Facts: Coverage of Children*, *available at* <https://www.kff.org/other/state-indicator/children-0-18/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited October 26, 2018).
18. A. Rossier Markus et al., "Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform," *Women's Health Issues* 23, no. 5 (2013): e273-e280.
19. Rosenbaum, *supra* note 11.
20. S. Rosenbaum et al., *Community Health Centers: Growing Importance in a Changing Health Care System* (Kaiser Family Foundation, 2018), *available at* <https://www.kff.org/medicaid/issue-brief/community-health-centers-growing-importance-in-a-changing-health-care-system/> (last visited October 26, 2018).
21. Medicaid and CHIP Payment and Access Commission, *Disproportionate Share Hospital Payments*, *available at* <https://www.macpac.gov/subtopic/disproportionate-share-hospital-payments/> (last visited October 26, 2018).
22. R. Rudowitz and R. Garfield, *10 Things to Know about Medicaid: Setting the Facts Straight* (Kaiser Family Foundation, 2018) *available at* <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/> (last visited October 26, 2018).
23. S. Rosenbaum, S. Schmucker, S. Rothenberg, and R. Gunsalus, *What Would Block Grants or Limits on Per Capita Spending Mean for Medicaid?* (New York: Commonwealth Fund, 2016) *available at* <http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2016/nov/1913_rosenbaum_medicaid_block_grants.pdf> (last visited October 26, 2018).
24. H. Katch, *Medicaid Works: Millions Benefit from Medicaid's Effective, Efficient Coverage* (Center on Budget and Policy Priorities, 2017) *available at* <https://www.cbpp.org/research/health/medicaid-works-millions-benefit-from-medicaids-effective-efficient-coverage> (last visited October 26, 2018).
25. See American Health Care Act**.**
26. Actuarial Report, *supra* note 2.
27. S. Sullivan, J. Eilperin, and K. Snell, "New Health Care Plan Stumbles Under Opposition from Governors," *Washington Post*, September 19, 2017, *available at* <https://www.washingtonpost.com/powerpost/renewed-obamacare-repeal-effort-dealt-a-blow-as-governors-come-out-in-opposition/2017/09/19/499478fe-9d51-11e7-9083-fbfddf6804c2_story.html?noredirect=on&utm_term=.c31caab6a116> (last visited October 26, 2018).
28. T. Coughlin et al., *What Difference Does Medicaid Make? Assessing Cost-Effectiveness, Access and Financial Protection under Medicaid for Low-Income Adults* (Kaiser Family Foundation, May 2013), *available at* <http://kff.org/medicaid/issue-brief/what-difference-does-medicaid-make-assessing-cost-effectiveness-access-and-financial-protection-under-medicaid-for-low-income-adults/> (last visited October 26, 2018).
29. A. Gates, R. Rudowitz, and J. Guyer, *An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers* (Kaiser Family Foundation, September 2014) *available at* <https://www.kff.org/medicaid/issue-brief/an-overview-of-delivery-system-reform-incentive-payment-waivers/> (last visited October 26, 2018).
30. See, e.g., Medicaid CHIP Payment and Access Commission (MACPAC), *Policy Options for Controlling Medicaid Spending on Prescription Drugs* (2017) *available at* <https://www.macpac.gov/wp-content/uploads/2017/09/Policy-Options-for-Controlling-Medicaid-Spending-on-Prescription-Drugs.pdf> (last visited October 26, 2018).
31. See U.S. Dept. of H.H.S., Centers for Medicare & Medicaid Services, State Medicaid Directors Letter (Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries) (SMD 18-0002) (Jan. 11, 2018); compare Jane Perkins, NHeLP Letter to CMS Regarding Work Requirements, *available at* <http://www.healthlaw.org/publications/browse-all-publications/nhelp-letter-to-cms-regarding-work-requirements#.Wst9X4jwaUk> (last visited October 26, 2018).
32. *Stewart v. Azar* 2018 WL 3203384 (D.D.C. June 29, 2018).



*The Journal of Law, Medicine & Ethics*, 46 (2018): 883-886. © 2018 The Author(s)

https://doi.org/10.1177/1073110518821984 Published online by Cambridge University Press