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Sara Rosenbaum
George Washington University, sarar@gwu.edu

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A PROGRAM FOR ALL SEASONS

SARA ROSENBAUM*

ABSTRACT

From its beginnings as a modest health care companion to cash welfare assistance, Medicaid has become foundational to the American health care system. Medicaid's success in insuring the poor while continually evolving in response to countless emerging health needs is the result of its public health character, which represents a fundamental departure from the eligibility and coverage strictures and norms on which other forms of insurance depend.

* J.D. Harold and Jane Hirsh Professor, Health Law and Policy, Milken Institute School of Public Health, George Washington University. I would like to express my gratitude to the Saint Louis University Law School and its wonderful health law program for providing me the opportunity to speak at its annual health law symposium. My deep gratitude as well to the Commonwealth Fund for its generosity over many years in supporting so many of our Medicaid research and analysis projects here at the School of Public Health. Special thanks go to two of the Fund's longest-serving and most talented staff members, Dr. Sara Collins and Ms. Melinda Abrams, colleagues and friends both.

I. INTRODUCTION

Anyone who has worked closely with Medicaid for any appreciable length of time—my own immersion began when the program was barely ten years old—will tell you the program is simply irreplaceable. From a purely practical perspective, Medicaid is a bargain compared to subsidized private health insurance,[1] with per capita costs well below those for a comparable amount of private insurance coverage.[2] What makes Medicaid so special is not its comparatively low cost compared to commercial plans, but its ability to shoulder so many responsibilities—beyond insuring over seventy million people[3]—that transcends the relatively straightforward task of protecting individuals against high health care costs. These responsibilities are equally essential to any nation's health system. The program has borne these duties, often in obscure ways that only those intimately familiar with its mysterious inner workings can fully grasp, and it has done so continually throughout its half-century of existence, adapting to emerging needs and changing circumstances.[4] Those who overlook Medicaid's remarkable, Protean qualities—whether advocates for block grants or for replacement with "Medicare-for-all"[5]—fail to grasp its singular programmatic structure. Medicaid's structure reflects its public welfare roots. However, over the decades, Medicaid has assumed a new mantle, one that aligns with broader public health norms of a full population embrace rather than the norms of insurance. Medicaid does not face the constraints that plague public or private insurance programs, those constraints being necessitated by the inherent nature of insurance and the concept of "risk pool[ing]."[6]

1. *See* CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 4 (2012) (comparing the per capita cost of Medicaid ($6000 under the CBO estimates in 2022) against those for Exchange enrollment ($9000 per capita for the same year)).

2. *See* John Holahan & Stacey McMorrow, *Medicare and Medicaid Spending Trends and the Deficit Debate*, 367 NEW ENG. J. MED. 393, 394 (2012) (explaining that per capita spending growth for private health insurance exceeds that of Medicaid spending growth).

3. *July 2019 Medicaid and CHIP Enrollment Data Highlights*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html (last updated Oct. 1, 2019). The Centers for Medicare and Medicaid Services report that in July 2019, 72,139,715 people were enrolled in Medicaid and its expanded Children's Health Insurance Program. *Id.*

4. Cindy Mann & Deborah Bachrach, *Medicaid as Health Insurer: Evolution and Implications,* COMMONWEALTH FUND (July 23, 2015), https://www.commonwealthfund.org/blog/2015/medicaid-health-insurer-evolution-and-implications.

5. Kevin Uhrmacher et al., *Where 2020 Candidates Stand on Medicare-for-all*, WASH. POST (Sep. 20, 2019), https://www.washingtonpost.com/graphics/politics/policy-2020/medicare-for-all/.

6. Mann & Bachrach, *supra* note 4; *Risk Pooling: How Health Insurance in the Individual Market Works*, AM. ACAD. ACTUARIES 1 (July 2017), https://www.actuary.org/sites/default/files/files/publications/RiskPoolingFAQ071417.pdf.

To be sure, Medicaid's massive size makes enormous budgetary demands on both federal and state governments. But given the sheer scope of the tasks assigned to it, Medicaid is strikingly efficient.[7] Furthermore, the program today rests on a half century of research documenting its impact on access to health care, improvements in health, and mortality itself.[8]

Medicaid's singular nature becomes especially clear when one moves among the various forms of U.S. health insurance as I have had occasion to do since the 1970s. Consider Medicaid, Medicare, the individual insurance market, and employer-sponsored health plans—even a superficial assessment of these coverage pathways underscores Medicaid's ability to respond in ways that mirror the mission of public health rather than the highly structured limits inherent in an insurance model. It is this fundamental difference that enables Medicaid to do things no other insurer can do, beginning—but not ending—with the act of insuring people whose health needs lie beyond the furthest reaches of even a generous insurance plan.[9]

Medicaid's transformation from a small Medicare companion to a foundation of the American health care system has hardly been a smooth one. The volume of Medicaid bashing at times has reached din level, and an enormous amount of ink has been spent on polemics advocating repeal.[10] Over its fifty-five-year life, Medicaid has faced three truly existential crisis periods, all of which involved an effort to effectively destroy its legal structure by imposing an aggregate limit on federal spending while stripping the statute of its essential requirements. These initiatives would have ended Medicaid's status as an individual guarantor of coverage for eligible people while also destroying its ability to continually adapt to ever-changing developments in health insurance

7. *See* John V. Jacobi, *Dangerous Times for Medicaid*, 33 J.L. MED. & ETHICS 834, 838 (2005).

8. A full literature review of Medicaid's impact on coverage, access, and health would be a lengthy article in and of itself. *See, e.g.*, Larissa Antonisse et al., *The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review*, KAISER FAM. FOUND. 1 (2019), http://files.kff.org/attachment/Issue-brief-The-Effects-of-Medicaid-Expansion-under-the-ACA-Findings-from-a-Literature-Review. This ongoing literature review, which nicely summarizes only those impact studies dating from the ACA, contains an incredible 708 separate sources covering literally dozens of studies. *Id.* For a classic study in the field, one of the first widely read evaluations of Medicaid and other War on Poverty health programs, see generally KAREN DAVIS & CATHY SCHOEN, HEALTH AND THE WAR ON POVERTY: A TEN-YEAR APPRAISAL (1978). The study documented Medicaid's impact on infant mortality among African American babies, the result of the program's impact on hospital access for their mothers. *See id.* at 32–33.

9. Jacobi, *supra* note 7.

10. There are countless such documents. Googling "Medicaid is broken" or "Medicaid is riddled with fraud" gives one hundreds of thousands of hits instantly. Perhaps the most recent example of just how large Medicaid, as the largest of all means-tested legal entitlement programs, looms for its opponents has been then-House-Speaker Paul Ryan's *A Better Way,* which devoted over twenty percent of its explanation regarding a new and better health care system to repealing Medicaid. *See* PAUL RYAN, A BETTER WAY: OUR VISION FOR A CONFIDENT AMERICA 25 (2016).

coverage, health care, and health itself. The first such run at the program came in 1981, when the Reagan administration attempted a federal spending cap. The second run at the ending the program occurred in 1995 as part of the "Gingrich revolution."[11] Most recently, of course, came the epic Affordable Care Act (ACA) "repeal and replace battle of 2017," featuring efforts to repeal the Act's seminal private insurance guarantee, reduce its tax subsidies, end Medicaid expansion funding, and block grant the underlying traditional Medicaid program—in other words, an agenda for Medicaid extending well beyond the ACA itself.[12]

What was so remarkable about these crises is that even in 1981, when Medicaid was a shadow of its current self, the lawmakers who fought to preserve it did so not only because of the coverage it guaranteed, but also in recognition of its irreplaceable qualities as a program that could rise to whatever occasion it had to confront, even ones not yet identified.[13] In the 1981 battle, Medicaid covered slightly more than 19.5 million people—about thirty percent as many as it did by 2017, when coverage projections for that year stood at seventy-three million. Similarly, in 1981, total spending stood at only around twenty-five billion dollars—a far cry from the nearly $600 billion mark that would be reached by 2017.[14] Indeed, Medicaid's unique, flexible qualities have been a recognized hallmark of the program since its original enactment.[15]

Since the demise of the 2017 repeal and replace effort, the Trump administration has not given up, of course. It has persisted by making a block grant replacement part of its annual budget,[16] as well as through regulatory

11. *See, e.g.*, Ron Elving, *Congress, 10 Years After the Gingrich Revolution*, NPR (Jan. 11, 2005), https://www.npr.org/templates/story/story.php?storyId=4278906; DAVID G. SMITH & JUDITH D. MOORE, MEDICAID POLITICS AND POLICY 122, 189 (2d ed. 2015).

12. *See generally, e.g.*, American Health Care Act of 2017, H.R. 1628, 115th Cong. (2017); Sara Rosenbaum, *The (Almost) Great Unraveling*, 43 J. HEALTH POL., POL'Y & L. 579, 586–94 (2018).

13. Spencer Rich, *Reagan Budget Means Drastic Cuts in Medicare and Medicaid Programs*, WASH. POST, (Aug. 21, 1981), https://www.washingtonpost.com/archive/politics/1981/08/21/reagan-budget-means-drastic-cuts-in-medicare-and-medicaid-programs/5c74d19a-dfdc-4c57-924f-feb27dc78f9c/.

14. *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., 2017 ACTUARIAL REPORT ON THE FINANCIAL OUTLOOK FOR MEDICAID 12 tbl.2 (2017).

15. ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID 51–52 (1974). This book is still considered the seminal history of the program.

16. A BUDGET FOR A BETTER AMERICA: FISCAL YEAR 2020 BUDGET OF THE U.S. GOVERNMENT 42 (2019). The document's cryptic reference to "enactment of legislation modeled after the Graham-Cassidy-Heller-Johnson" proposal from September 2017—the final legislative gasp of the failed repeal/replace effort—is a reference to a legislative concept (that never became formalized as a bill before it collapsed at the end of September). *See id.* at 42–43. This legislative concept would fold Medicaid and premium tax credits together in one giant block grant, then significantly reduced and allocated to states. *See id.* In other words, the President's fiscal year 2020

strategies aimed at achieving what its legislative push was unable to accomplish. An especially prominent strategy has been its concerted effort, using experimental authority under Section 1115 of the Social Security Act,[17] to drive deep enrollment reductions through demonstrations aimed at restricting eligibility through work requirements and other restrictions.[18] As of August 2019, a series of court decisions had halted the experiments,[19] and the administration had appealed.[20] A second such strategy has involved the administration's aggressive efforts to remove legal immigrants from Medicaid by vastly expanding the circumstances under which Medicaid enrollment will count in determining whether applicants are public charges and therefore ineligible for admission or adjustment to permanent residence status.[21]

But despite it all, Medicaid has prevailed, with its entitlement features and financing structure intact; today, the program covers more than one-fifth of the American population.[22]

budget proposal was to revive the Medicaid block grant—an easy way to rack up more than a trillion dollars in federal spending cuts to offset the major loss of revenue flowing from the 2017 tax cuts—or so the administration assumed. *See generally* PAUL N. VAN DE WATER ET AL., 2020 TRUMP BUDGET: A DISTURBING VISION 1–2 (2019).

17. 42 U.S.C. § 1315(a) (2018).

18. Sara Rosenbaum et al., *State 1115 Proposals to Reduce Medicaid Eligibility: Assessing Their Scope and Projected Impact*, COMMONWEALTH FUND (Jan. 11, 2018), https://www.commonwealthfund.org/blog/2018/state-1115-proposals-reduce-medicaid-eligibility-assessing-their-scope-and-projected.

19. Stewart v. Azar (*Stewart I*), 313 F. Supp. 3d 237, 246, 265 (D.D.C. 2018); Stewart v. Azar (*Stewart II*), 366 F. Supp. 3d 125, 156 (D.D.C. 2019); Gresham v. Azar, 363 F. Supp. 3d 165, 183–85 (D.D.C. 2019); Philbrick v. Azar, No. 19-773, 2019 U.S. Dist. LEXIS 125675, at *15 (D.D.C. July 29, 2019). *See also* Sara Rosenbaum, *"We Have All Seen This Movie Before": Once Again, a Federal Court Vacates HHS Approval of a Medicaid Work Experiment*, HEALTH AFF. (Aug. 2, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190801.892432/full/.

20. *See, e.g.*, Rosenbaum, *supra* note 19.

21. *See generally* Inadmissibility on Public Charge Grounds, 84 Fed. Reg. 41292 (Aug. 14, 2019) (to be codified at 8 C.F.R. pts. 103, 212, 213, 214, 245, 248); Sara Rosenbaum, *The New "Public Charge" Rule Affecting Immigrants Has Major Implications for Medicaid and Entire Communities*, COMMONWEALTH FUND (Aug. 15, 2019), https://www.commonwealthfund.org/blog/2019/new-public-charge-rule-affecting-immigrants-has-major-implications-medicaid-and-entire; Wendy Parmet, *The Trump Administration's New Public Charge Rule: Implications for Health Care & Public Health*, HEALTH AFF. (Aug. 13, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190813.84831/full/; *Changes to Public Charge Inadmissibility Rule: Implications for Health and Health Coverage*, KAISER FAM. FOUND. (Aug. 12, 2019), http://files.kff.org/attachment/Fact-Sheet-Changes-to-Public-Charge-Inadmissibility-Rule-Implications-for-Health-and-Health-Coverage.

22. Phil Galewitz, *Medicaid Covers All That? It's the Backstop of America's Ailing Health System*, KAISER HEALTH NEWS (Sept. 25, 2017), https://khn.org/news/medicaid-has-a-bulls-eye-on-its-back-which-means-no-one-is-entirely-safe/.

II. WHY THE MEDICAID PROGRAM SUCCEEDS

What gives Medicaid its power? Size certainly matters. After all, how does one replace such a large insurer—an essential step under an aggregate spending cap given the tens of millions of people states would be forced to shed?[23] Assuming that Medicaid cap proponents do want to keep people insured at least to some degree, the "what next" problem looms large and, of course, has turned out to be precisely the question that proponents of repeal and replace never could answer. The solution does not lie in simply encouraging workers to rely on job-based benefits, even though such coverage represents the nation's largest single source of health insurance. Employer-sponsored plans remain popular, but for decades now the model has been steadily eroding[24]—the result of shifting labor patterns, fundamental changes in the nature of work, and rapidly escalating costs that leave coverage unaffordable.[25] For low wage workers, employer coverage offers are far less common to begin with, given their limited compensation and frequently part-time job status.[26] Furthermore, even when insurance is offered to lower-wage employees, employer contributions toward premium costs are insufficient to make coverage affordable for the lowest paid workers.[27]

One might turn to the individual market by expanding the ACA's federal tax credits for low and moderate income people to support those with incomes falling below tax credits' lower eligibility threshold of 100 percent of the federal poverty level.[28] But refundable tax credits are an impractical solution for the very poor who are not taxpayers, given the need to reconcile tax credits against reported income.

Furthermore, enrollment in the health insurance Marketplace established under the ACA stood at 10.6 million people with "effectuated" coverage in early

23. *See* CONG. BUDGET OFFICE, LONGER-TERM EFFECTS OF THE BETTER CARE RECONCILIATION ACT OF 2017 ON MEDICAID SPENDING 1–3 (2017) (estimating the out-year effects on Medicaid of the draft Senate version of repeal/replace).

24. U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS-97-122, PRIVATE HEALTH INSURANCE: CONTINUED EROSION OF COVERAGE LINKED TO COST PRESSURES 6 (1997).

25. *Id.* at 24–26.

26. GARY CLAXTON ET AL., KAISER FAM. FOUND., EMPLOYER HEALTH BENEFITS: 2018 ANNUAL SURVEY 61, 66 (2018) (providing that offer rates are associated with firms with fewer low-wage employees and few high wage employees and that offer rates are particularly low in retail job industries).

27. *See* U.S. Bureau of Labor Statistics, *Lower-wage Workers Pay More Than Higher-wage Workers for Employer-provided Medical Care Benefits*, ECON. DAILY (Jan. 14, 2019), https://www.bls.gov/opub/ted/2019/lower-wage-workers-pay-more-than-higher-wage-workers-for-employer-provided-medical-care-benefits.htm?view_full (showing that for individual coverage, employers actually contribute slightly less to the premiums of their lowest wage employees—a $398.51 monthly contribution compared to $440.48 for higher-wage employees).

28. *Eligibility for the Premium Tax Credit*, INTERNAL REVENUE SERV., https://www.irs.gov/affordable-care-act/individuals-and-families/eligibility-for-the-premium-tax-credit (last updated Mar. 29, 2019).

2019.[29] Eighty-seven percent of those individuals (9.3 million) received advance premium tax credits, with a great majority of this group also receiving cost sharing assistance.[30] The individual insurance market is like a "hothouse flower" compared to Medicaid's hardy perennial characteristics.[31] For the individual market to remain stable, strict limits must apply akin to those found under employer plans. Enrollment must be restricted, and benefits must be limited; cost sharing assistance, even when generous, must create some "skin in the game" in order to keep utilization down. Compared to Medicaid's unique enrollment and coverage rules, the individual market is no substitute for a safety net insurer that can embrace people in whatever state of health care need they find themselves.[32]

Medicaid has grown exponentially because federal and state lawmakers alike have recognized its utility as a strategic pathway for addressing a seemingly endless line of population needs and market failures: insurance for the poorest children and pregnant women unable to gain access to employer coverage even when it was offered;[33] a means for ensuring home and community-based care for children with severe disabilities who otherwise risked institutionalization (a reform instigated by President Reagan, essentially at the same time his administration was leading a Medicaid block grant effort);[34] a means for using Medicaid to make Medicare, with its substantial premiums and high cost-sharing, accessible to the poorest beneficiaries, much like the way Medi-Gap plans fill in Medicare's holes in the case of the non-low income population;[35] coverage of uninsured people with diagnosed breast or cervical

29. *Early 2019 Effectuated Enrollment Snapshot*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Aug. 12, 2019), https://www.cms.gov/newsroom/fact-sheets/early-2019-effectuated-enrollment-snapshot. The term "effectuated enrollment" signifies people who have paid their premiums. *Id.*

30. *Id.*

31. Sara Rosenbaum, *Hardy Perennials and Hothouse Flowers: What Can We Learn from "Repeal and Replace"?*, MILBANK Q. (Aug. 2017), https://www.milbank.org/quarterly/articles/hardy-perennials-hothouse-flowers-can-learn-repeal-replace.

32. *See id.*; Elise Gould, *Increased Health Care Cost Sharing Works as Intended: It Burdens Patients Who Need Care the Most*, ECON. POL'Y INST. (May 8, 2013), https://www.epi.org/files/2013/increased-health-care-cost-sharing-works.pdf.

33. Amy Chen & Emily Hayes, *Q&A on Pregnant Women's Coverage Under Medicaid and the ACA*, NAT'L HEALTH L. PROGRAM (Sept. 2018), https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/09/QA-on-Pregnant-Women's-Coverage.pdf; JULIA PARADISE ET AL., KAISER FAM. FOUND., MEDICAID AT 50 1–3 (May 6, 2015), http://files.kff.org/attachment/report-medicaid-at-50.

34. ROBERT GETTINGS ET AL., NAT'L COUNCIL ON DISABILITY, A MEDICAID BLOCK GRANT PROGRAM: IMPLICATIONS FOR PEOPLE WITH DISABILITIES 27–28 (May 22, 2013), https://ncd.gov/sites/default/files/NCD_BlockGrant_ReportApr10FINAL508_0.pdf; *How Medicaid Protects Children with Special Health Care Needs*, FAMS. USA 5 (June 2018).

35. Diane Rowland, *The Medicare and Medicaid Partnership at Age 50*, 39 GENERATIONS: J. AM. SOC'Y ON AGING 35, 35–37 (2015).

cancer;[36] expanded coverage of prevention and treatment drugs and community-based care for persons living with HIV/AIDS,[37] treatment for which Medicaid was the major source during the height of the AIDS crisis—so much so that Medicaid now accounts for more than twenty percent of all domestic spending on HIV/AIDS treatment;[38] and the biggest single source of insurance for people with opioid use disorder, regardless of income status.[39]

What accounts for Medicaid's ability to continually evolve in response to need—its ability to accept people into coverage at the time that health care is needed rather than only at defined "open-enrollment periods," its ability to provide comprehensive coverage for primary, acute, and long-term services and supports at nominal cost sharing? The answer to this question lies in the financing model used to support the program, one that relies on broad-based federal, state, and, in some states, local taxes rather than payroll taxes and premiums that fall directly onto individuals.[40] Unlike other insurance models, Medicaid's costs are spread across all citizens, much like other public health interventions.[41] For a program to be able to move with flexibility, the funding model needs to be flexible. We see this at times in other programs. For example, consider the fact that seventy-one percent of the funds needed to support the Medicare Part D outpatient prescription drug coverage program come from general revenue.[42] Where Medicaid is concerned, broad-based financing supports the model entirely.

Payors necessarily behave in accordance with the financing base on which they rest. In order to accommodate a financing system that rests predominantly, if not exclusively, on individuals and individual businesses (in the case of employer plans), insurers maintain restrictive enrollment and coverage rules and update benefit design only slowly. For example, insurers have lengthy grace

36. U.S. GOV'T ACCOUNTABILITY OFF., GAO-09-384, MEDICAID: SOURCE OF SCREENING AFFECTS WOMEN'S ELIGIBILITY FOR COVERAGE OF BREAST AND CERVICAL CANCER TREATMENT IN SOME STATES 6 (2009).

37. *U.S. Federal Funding for HIV/AIDS: Trends Over Time*, KAISER FAM. FOUND. (Mar. 5, 2019), http://files.kff.org/attachment/Fact-Sheet-US-Federal-Funding-for-HIVAIDS-Trends-Over-Time.

38. *Id.*; *Medicaid and HIV*, KAISER FAM. FOUND. (Oct. 1, 2019), https://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/.

39. Kendal Orgera & Jennifer Tolbert, *The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment*, KAISER FAM. FOUND. 4 (2019), http://files.kff.org/attachment/Issue-Brief-The-Opioid-Epidemic-and-Medicaids-Role-in-Facilitating-Access-to-Treatment.

40. *See* Laura Snyder & Robin Rudowitz, *Medicaid Financing: How Does it Work and What are the Implications?*, KAISER FAM. FOUND. 5 (2015), http://files.kff.org/attachment/issue-brief-medicaid-financing-how-does-it-work-and-what-are-the-implications.

41. *See* Juliette Cubanski et al., *The Facts on Medicare Spending and Financing*, KAISER FAM. FOUND. 6 (2019), http://files.kff.org/attachment/Issue-Brief-Facts-on-Medicaid-Spending-and-Financing.

42. *Id.* at 7.

periods to come into compliance with updated recommendations for immunizations and preventive services coverage under the ACA's preventive services coverage rules.[43] The need for control is especially acute in a re-engineered regulatory system that attempts to use a market response (private insurance sold in the group or individual markets) to attack a population health problem (people excluded by virtue of pre-existing conditions).[44] The tax subsidies may be financed out of general revenue, but the products that make the system go are not, except for those with low incomes. Even then, the subsidy is only partial.[45]

By contrast, Medicaid rests on a fundamentally different funding base and thus can maintain design features diametrically opposed to those on which an insurance market depends.[46] For example, people can enroll in Medicaid at any time; the program has no open enrollment rules.[47] Eligibility can be retroactive to cover bills incurred before the application was made but when the individual was eligible.[48] Benefits are broad and cost sharing is low for beneficiaries.[49] To be sure, to hold costs down, there is a significant tradeoff in the form of lower payments for most types of providers for the medical and hospital care they furnish.[50] Critics point to access constraints that can result from lower reimbursement rates, but Medicaid's documented impact on access to care and health outcomes tends to underscore the somewhat limited effects that these restrictions ultimately have.[51]

Medicaid reflects public health norms rather than those selective features that characterize insurance markets. This quality in turn has made it the logical and powerful platform on which to base national responses to population health

43. *See generally FAQs About Affordable Care Act Implementation (Part XIX)*, CMS (May 2, 2014), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html.

44. Merrill Goozner, *Editorial: Discriminating Against Pre-Existing Conditions Will Hurt Patients and Providers*, MOD. HEALTHCARE (Jun. 16, 2018), https://www.modernhealthcare.com/article/20180616/NEWS/180619934/editorial-discriminating-against-pre-existing-conditions-will-hurt-patients-and-providers.

45. *See generally Medicare Low Income Subsidy: Get Extra Help Paying for Part D*, NAT'L COUNCIL ON AGING (Oct. 2, 2019), https://www.ncoa.org/economic-security/benefits/prescriptions/lis-extrahelp/.

46. *See* Robin Rudowitz et al., *10 Things to Know About Medicaid: Setting the Facts Straight*, KAISER FAM. FOUND. 8 (2019), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/.

47. 42 U.S.C. § 1396a(a)(8) (2018). Instead, Medicaid is guided by a "prompt assistance" standard. *Id.*

48. *Id.* § 1396a(a)(34). The retroactivity period is limited to three months. *Id.*

49. Samantha Artiga et al., *Current Flexibility in Medicaid: An Overview of Federal Standards and State Options*, KAISER FAM. FOUND. 2, 8 (2017), https://www.kff.org/report-section/current-flexibility-in-medicaid-issue-brief/.

50. *Id.* at 10.

51. Rudowitz et al., *supra* note 46, at 10.

problems. These responses have ranged from expanded eligibility for high-need populations to special demonstration and experimental undertakings, to using the power of Section 1115 to address mass disasters, whether naturally occurring or the result of human behavior.[52] In addition, Medicaid's special flexibility around provider payment (in many cases these rules parallel special payment principles also found in Medicare) has provided states with a means of targeting additional resources to hospitals and clinics that anchor health care in the poorest communities, which often need supplemental resources given sicker patients that require more intensive services.[53] Over its life, Medicaid's disproportionate share hospital (DSH) payment program has invested hundreds of billions of dollars in safety net hospitals and health systems.[54] Similarly, Medicaid's special "federally qualified health center"[55] and "rural health clinic"[56] payment rules have infused billions of dollars in additional funding into rural primary care clinics and community health centers that anchor primary health care in the nation's most medically underserved rural and urban communities.[57]

Medicaid's strengths go beyond its standard structure, laid out in a remarkably complex statute. Because Medicaid is one of the Social Security Act programs covered by the special experimental authority found under Section 1115 of the Social Security Act, this unique program feature has enabled state Medicaid programs to undertake true health system development investment demonstrations that go beyond coverage and payment. Section 1115 authorizes the Secretary of Health and Human Services to undertake demonstrations that he or she finds are likely to promote program objectives.[58] Since its 1962 enactment, Section 1115 has provided the means by which federal officials, in

52. *See, e.g.*, Elizabeth Hinton et al., *Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers*, KAISER FAM. FOUND. 5, 8 (2019), https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-the-current-landscape-of-approved-and-pending-waivers/.

53. *See* Peter Cunningham et al., *Understanding Medicaid Hospital Payments and the Impact of Recent Policy Changes*, KAISER FAM. FOUND. 5–7 (2016), https://www.kff.org/report-section/understanding-medicaid-hospital-payments-and-the-impact-of-recent-policy-changes-issue-brief/.

54. *Id.* at 3, 6. *Medicaid Disproportionate Share Hospital (DSH) Payments*, MEDICAID, https://www.medicaid.gov/medicaid/finance/dsh/index.html (last visited Oct. 13, 2019).

55. *Medicaid Payment Policy for Federally Qualified Health Centers*, MACPAC 1–2 (2017), https://www.macpac.gov/wp-content/uploads/2017/12/Medicaid-Payment-Policy-for-Federally-Qualified-Health-Centers.pdf.

56. Rachel Donlon, *Steps to Engage Rural Health Clinics in Medicaid Value-Based Purchasing Initiatives*, NAT'L ACAD. FOR ST. HEALTH POL'Y 1 (2017), https://nashp.org/wp-content/uploads/2017/11/Rural-Health-Clinic-Fact-Sheet.pdf.

57. *Medicaid Payment Policy for Federally Qualified Health Centers*, *supra* note 55, at 1–3. Donlon, *supra* note 56, at 1.

58. 42 U.S.C. § 1315(a) (2018). *See generally* Jonathan R. Bolton, *The Case of the Disappearing Statute: A Legal and Policy Critique of the Use of Section 1115 Waivers to Restructure the Medicaid Program*, 37 COLUM. J.L. & SOC. PROBS. 91 (2003) (providing an in-depth background on Section 1115 waivers).

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cooperation with states, can test and evaluate new approaches to state-administered public assistance programs that are likely to improve their performance for the people they serve.[59] To be sure, the Trump administration has (unsuccessfully to date) attempted to use Section 1115 to undermine Medicaid's core purpose of providing medical assistance to the poor.[60] But this has not been the norm; over decades, Section 1115 has enabled demonstrations that tested program improvements, such as eligibility expansion to poor adults,[61] the expansion of Medicaid coverage design to favor home and community-based services for people for whom institutionalization is medically unnecessary,[62] and the transition to managed care models that integrate coverage and care access.[63] Building on this tradition of using Section 1115 not simply to alter eligibility and benefits, but also to fundamentally transform how care is delivered, the Obama administration used its demonstration power to allow states to test new approaches to the organization and delivery of health care itself.[64] Through Section 1115, the federal government has used Medicaid to fund critical capital investments in new service sites, staff growth, develop care teams that can integrate health and social services, and adopt modern health information technology capabilities that over time can measure health care quality and improve efficiency.[65] There simply is no counterpart to this special legal authority, one that enables Medicaid to be fully transformational, extending beyond the traditional roles of insurance.

III. CONCLUDING THOUGHTS

The American health care system faces multiple challenges. Some of these challenges can be met with a conventional insurance response in the form of stable coverage over time that can make appropriate health care affordable. Many challenges, however, occur at the population level and demand more systemic responses to develop and anchor health services where they are needed, test new approaches to health care for vulnerable populations, ensure access for

59. Bolton, *supra* note 58, at 99.

60. *See, e.g.*, *Stewart I*, 313 F. Supp. 3d 237, 272 (D.D.C. 2018); *Stewart II*, 366 F. Supp. 3d 125, 153–54 (D.D.C. 2019).

61. *E.g.*, Sara Rosenbaum, *Weakening Medicaid From Within,* AM. PROSPECT (Oct. 19, 2017), https://prospect.org/article/weakening-medicaid-within.

62. *See, e.g.*, *id.*

63. *E.g.*, *id.*

64. *See id.*

65. *See* Sara Rosenbaum et al., *Community Health Centers and Medicaid Delivery and Payment Reform: A Closer Look at Massachusetts and New York*, MILKEN INST. SCH. PUB. HEALTH 4 (2019), http://gwhpmmatters.com/sites/default/files/2019-03/Community%20Health%20Centers%20%26%20Medicaid%20Delivery%20%26%20Payment%20Reform%2C%20Mass.%20N.Y.%20%28Rosenbaum%2C%20Wachino%2C%20Morris%2C%20Gunsalus%29%20Mar%207%2C%202019.pdf.

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people who fall through cracks or are otherwise ineligible for insurance, and ensure a needed response to public health threats and mass disasters. These are the things that Medicaid does that go beyond its core role as an insurer of individuals—these are capabilities that any health system needs.

Even in the wake of national reform, the nation's approach to insurance remains fragmented and inevitably filled with gaps, particularly for people who lack health and economic stability and populations such as recently-arrived immigrants, undocumented individuals, and families who find themselves outside any formal insurance pathway.[66] We will always need investments in health care infrastructure and in delivery innovations, and we will always need a means of rapidly responding to population health threats that have implications for entire communities.

Regardless of the insurance choices we might make in the future, this nation will always need a source of flexible, public health funding, a utilitarian player of sorts that, despite its size, can move in multiple, simultaneous directions with relative nimbleness. For the United States, that program is Medicaid. May it always endure.

66. Wendy E. Parmet, *Immigration and Health Care Under the Trump Administration,* HEALTH AFF.: BLOG, (Jan. 18, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180105.259433/full/.