Saint Louis University Journal of Health Law & Policy

Volume 13
Issue 1 *The Struggle for the Soul of Medicaid*

Article 6

12-6-2019

Justice and the Struggle for the Soul of Medicaid

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JUSTICE AND THE STRUGGLE FOR THE SOUL OF MEDICAID

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Of all the forms of inequality, injustice in healthcare is the most shocking and inhuman.[1]

Dr. Martin Luther King, Jr.

Speak up for those who cannot speak for themselves; ensure justice for those being crushed. Yes, speak up for the poor and helpless, and see that they get justice.

Proverbs 31:8-9 (NLT)

Chief among the structural forces creating unjust access to health-promoting opportunities and resources is subordination based on markers of perceived difference, such as race, gender, sexuality, and class. . . . From this perspective, the problem of health disparities is ultimately a problem of justice.[2]

Angela P. Harris and Aysha Pamukcu

ABSTRACT

The soul of Medicaid is and always has been to achieve justice in health care. Medicaid at its inception was designed to ensure that the most vulnerable members of society are not excluded from access to good health that all others enjoy. Yet, as the title of this symposium aptly reflects, "The Struggle for the Soul of Medicaid" remains vulnerable to repeated and relentless political attacks. Why is this so, given that the program finances care for nearly sixty-four million Americans?

This article posits that Medicaid is vulnerable because our nation's commitment to justice in health care remains uncertain. Historically, our commitment to justice in America has been limited by our willingness to bear

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1. Charlene Galarneau, *Getting King's Words Right*, 29 J. HEALTH CARE FOR POOR & UNDERSERVED 5, 5 (2018).

2. Angela P. Harris & Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*, UCLA L. REV. (forthcoming 2019) (manuscript at 3) (on file with SSRN).

the cost required to achieve justice. Moreover, our commitment has often been further limited by our inability to empathize with people who need Medicaid assistance in order to gain access to health care. We have limited the program to the "categorically" needy. Those who "deserve" help gaining access to health care. And more recently, some have used work requirements to ensure that Medicaid health benefits are meted out only to those worthy of receiving them. In contrast, the legislative purpose of the Act was so clear to its proponents, and so aligned with their shared foundational values as well as the values upon which our democracy rests, that in 1965, little more needed to be said in defense of Medicaid. That it provided a nationwide safety net for many of society's poor and destitute to receive health care, regardless of their ability to pay, may have been justification enough for the program.

However, simply identifying justice as the ethical value that lies at the soul of the Medicaid program cannot save it. Justice takes many forms, and its many expressions can serve to justify competing and even mutually exclusive ends where Medicaid is concerned. Egalitarian conceptualizations inspire Medicaid's communitarian commitment to provide access to health care for society's neediest to equalize the opportunity to participate in society. Utilitarian justice may aim to maximize societal health but might not accomplish these ends by identifying some poor or needy members of society as more deserving than others. And libertarian justice ideals counsel minimizing the cost burden that Medicaid places on non-beneficiaries. Notwithstanding the epistemological struggle, the Medicaid program remains quite popular with Americans, regardless of party affiliation. Republicans learned this during their failed multiple efforts to repeal-and-replace the Affordable Care Act.

This article argues that the justice that originally motivated the Medicaid mission has survived as the program's chief animating principle. That egalitarian vision of justice compels policymakers to stretch Medicaid's already scarce and over-burdened resources far beyond the clinical setting to rectify inequitable distribution of the social and environmental risk factors that disproportionately threaten the health of Medicaid-eligible populations. The unfairness of this additional burden on the program is not trivial. We already ask far too much of the program. Yet, the point of this article is to clarify why and how Medicaid can do even more than it does today to fulfill the mandates of justice, and thereby contribute substantially to nation-wide health equity.

I. INTRODUCTION

This article posits that the soul of Medicaid is and always has been to achieve justice in health care. Yet, as the title of this symposium aptly reflects, "The Struggle for the Soul of Medicaid" continues because our nation's commitment to justice in health care remains open to question. Historically, our commitment to justice in America has always been limited by our willingness to bear the *cost* required to achieve justice. Moreover, our commitment has often been further limited by our inability to empathize with people who need Medicaid assistance in order to gain access to health care. We have limited the program to the "categorically" needy. Those who "deserve" help gaining access to health care. And more recently, some have used work requirements to ensure that Medicaid health benefits are meted out only to those worthy of receiving them. In contrast, Medicaid at its inception was designed to ensure that the most vulnerable members of society are not excluded from access to good health that all others enjoy. The program was premised on the fairness of affording everyone an equal opportunity to be healthy. Thus, justice is the "soul" of the Medicaid program. Put another way, justice—in the Rawlsian sense—is a core principle and essential reason for the Medicaid program's existence. Justice, in a spiritual sense, is the purpose that transcends the Medicaid program's physical existence. However, to many, justice is strained by Medicaid's spiraling costs, which, driven by the increasing underlying cost of health care, has dramatically increased the shared burden of paying for the access to health care that Medicaid affords. Against the reality of scarce rather than unlimited resources available for health care, the true struggle for the soul of Medicaid lies in the unresolved debate about justice itself. The complex struggle for the soul of Medicaid explored in this article examines conflicting views of justice and their implications for the direction and purpose of the Medicaid program. These views are in tension with the cost that achieving or failing to achieve health justice imposes on us all. Put simply, the thesis of this article is that we must add to Dr. Martin Luther King, Jr.'s exhortation—that of all forms of inequality, injustice in health care is not only the most shocking and inhuman, but it is also the costliest.

Because Medicaid was passed without significant legislative debate, leading scholars have suggested the program was merely an "afterthought" to the more politically popular Medicare program.[3] This may be true. However, I suggest another view of the paucity of Medicaid's legislative record. Rather than the conclusion that the program "involved significantly less philosophical or political thought" than its public health insurance counterpart, it may have been that the legislative purpose of the Act was so clear to its proponents, and so aligned with their shared foundational values as well as the values upon which

3. Nichole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 444–45 (2011).

our democracy rests, that in 1965, little more needed to be said in defense of Medicaid. That it provided a nationwide safety net for the many of society's poor and destitute to receive health care, regardless of their ability to pay, may have been justification enough for the program.[4] By this reckoning, the Medicaid proposal satisfied those seeking to incrementally inch ever closer toward their ultimate goal of ensuring universal access to health care, by ensuring access to health insurance for all.[5] Plausibly, this is the reason Medicaid overcame the objections of those vehemently opposed to "socialized medicine," and wary of the federal government's interference in local affairs, may have nonetheless seen the need for providing at least temporary aid and assistance to those who are destitute.[6] Today, the struggle for the soul of Medicaid is ongoing not merely because our nation has wandered woefully far away from its fundamental goal of ensuring access to basic medical services for all, but also because the cost of the program has grown exponentially. According to historians Rosemary and Robert Stevens, Medicaid was enacted "amid great hope on the part of the liberals as the so-called 'sleeper' of the Social Security Act of 1965."[7] Yet, soon after it passed, commentators were hailing the program a failure because it was so expensive.[8] In its first five years, Medicaid exceeded projections by $5.5 billion per year while it was originally projected to cost less than $1 billion per year.[9] The program continues to be expensive. In Fiscal Year 2017, total federal and state Medicaid spending was $577 billion. It is the third largest program in the domestic federal budget, equaling 9.5% of all federal spending. Critics of the program have sought to contain its costs, most commonly by converting funding sources to block grants.[10] Some go so far as to disparage its participants, most infamously by labeling them "welfare queens."[11] In both instances, the cost containment efforts are focused on patients—the recipients of the Medicaid dollar—as though they represent the primary solution for containing Medicaid costs. I argue here that they do not. Block grants may contain the share of costs borne by state governments, but

4. *Id.* at 436.

5. Wilbur J. Cohen, *Reflections on the Enactment of Medicare and Medicaid*, HEALTH CARE FINANCING REV., 1985 supp., at 3, 9–10.

6. *Id.* at 9.

7. Rosemary Stevens & Robert Stevens, *Medicaid: Anatomy of a Dilemma*, 35 LAW & CONTEMP. PROBS. 348, 348 (1970).

8. *Id.* at 349–50.

9. *Id.* at 349.

10. Robin Rudowitz et al., *10 Things to Know About Medicaid: Setting the Facts Straight*, KAISER FAM. FOUND. 8, 11 (2019), http://files.kff.org/attachment/Issue-Brief-10-Things-to-Know-about-Medicaid-Setting-the-Facts-Straight.

11. *See generally* JOSH LEVIN, THE QUEEN: THE FORGOTTEN LIFE BEHIND AN AMERICAN MYTH (1st ed. 2019).

block grants do "nothing to reduce the cost of care" delivery.[12] Thus, as health care costs rise, Medicaid beneficiaries in block grant states will either receive less care, or find they are no longer eligible for care.[13]

Notwithstanding the epistemological struggle, the Medicaid program remains quite popular with Americans, regardless of party affiliation. Republicans learned this during their failed multiple efforts to repeal-and-replace the Affordable Care Act.[14] The majority of Democrats (eighty-four percent), Independents (seventy-six percent), and Republicans (sixty-one percent) hold a favorable view of Medicaid.[15] According to a Kaiser Family Foundation poll conducted in 2017, most think Medicaid works well for low-income people and few Americans want a decrease in federal spending on Medicaid. When asked to think about the country's health priorities in the federal budget, few (twelve percent) say they want to see the President and Congress decrease spending on Medicaid, while four in ten say they want increased spending.[16] About half (forty-seven percent) say they want the President and Congress to keep Medicaid spending about the same. Moreover, the public generally opposes Medicaid block grants but does favor allowing states to have more flexibility to determine which groups of people and what services are covered under the program.[17] The reason for this general support, I suggest, is that the majority of Americans share the core fairness principles that animate Medicaid as a way to give all people access to health care. In short, they see the program as a way for the country to "do justice."[18]

This article argues that the struggle for the soul of Medicaid is driven by competing views of justice. Using broad strokes, I suggest that the three major perspectives on justice have all influenced formation and reform efforts that shape the Medicaid program. Medicaid has overcome objections and survived efforts to eliminate it altogether because the program, in some form, continues to serve utilitarian, egalitarian, and libertarian views of justice. While I do not take a deep dive here into the theoretical or philosophical scholarship, I do in the end conclude that a Rawlsian approach to the problem of health inequity counsels that despite its flaws, Medicaid is the appropriate program and most

12. John Kitzhaber & Bruce Goldberg, *A Better Way to Contain Medicaid Costs*, MILBANK: THE MILBANK BLOG (June 13, 2019), http://www.milbank.org/2019/06/a-better-way-to-contain-Medicaid-costs/.

13. *Id.*

14. Michael McCarthy, *US Republican Attempt to Repeal and Replace Affordable Care Act Collapses*, BMJ (July 19, 2017), https://www.bmj.com/content/358/bmj.j3508.

15. Rudowitz et al., *supra* note 10, at 10.

16. Ashley Kirzinger et al*., Kaiser Health Tracking Poll: Future Directions for the ACA and Medicaid*, KAISER FAM. FOUND. (Feb. 24, 2017), https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-future-directions-for-the-aca-and-medicaid/.

17. *Id.*

18. *See generally* Karen Dillon, *'Medicaid 23' Protesters' Mass Trial Gets Under Way*, PITCH (Aug. 15, 2016), https://www.thepitchkc.com/medicaid-23-protesters-trial-starts/.

hopeful public policy vehicle through which to offer fair equality of opportunity for healthy lives to low-wealth communities in this country.

This article argues that the justice motivation at the core of the Medicaid mission compels policymakers to stretch its already scarce and over-burdened resources far beyond the clinical setting to rectify inequitable distribution of the social and environmental risk factors that disproportionately threaten the health of Medicaid-eligible populations. The unfairness of this additional burden on the program is not trivial. Medicaid is a program that currently reimburses physician providers eighty-eight cents on the dollar and yet, together with the Children's Health Insurance Program (CHIP), covers over seventy-four million enrollees, more than any other single health insurance program in the nation.[19] We already ask far too much of the program. Yet, the point of this article is to clarify why this is so, and to argue that Medicaid can do even more to fulfill its stated and intended goals.

To justify my claim, I will appeal to the heart and soul of what Medicaid is intended to do. I hope to demonstrate that the foundational objectives of the program remain ones to which the majority of Americans are committed. Similarly, those who are critics or opponents of Medicaid remain similarly aligned with those who, at its inception, misunderstood or misrepresented its purpose. Clarity on its purpose might dispel some myths that stand in the way of the program reaching its full potential and could rekindle courageous support for the program's commitment to reimburse for care that is "medically necessary." The article proceeds in three parts. First, I will use evidence of the debate that surrounded Medicaid's enactment to demonstrate its distributive roots. I conclude that, at its inception, Medicaid was designed to serve egalitarian justice. Second, I will suggest that the reform efforts that appear most threatening to the Medicaid program may best be understood as efforts to serve justice from utilitarian and libertarian perspectives. Yet, I suggest, the reason for the program's enduring popularity lies in the fact that more Rawlsian—that is, equitable—conceptualizations of Medicaid continue to capture the public imagination and are, in fact, most consistent with the program's initial purpose. Therefore, in Part V of the article, I propose fully embrace the relationship between Medicaid and the social justice model articulated by Madison Powers and Ruth Faden in 2006. I apply this model to argue for using Medicaid as a way to finance equal access to the social determinants of health beyond health care in order to meaningfully contribute to health equity in low wealth communities

19. *State Health Facts Data: Monthly Child Enrollment in Medicaid and CHIP*, KAISER FAM. FOUND. (May 2017), https://www.kff.org/medicaid/state-indicator/total-medicaid-and-chip-child-enrollment/?currentTimeframe=30&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; AMER. HOSP. ASSOC., UNDERPAYMENT BY MEDICARE AND MEDICAID FACTSHEET 2 (2017), https://www.aha.org/system/files/2018-01/medicaremedicaidunderpmt%202017.pdf.

nation-wide. This, I argue, is what justice demands of Medicaid, and of our nation.

II. EGALITARIAN JUSTICE IN MEDICAID: HEALTH CARE FOR THE NEEDY

Judith Moore and David Smith have explained clearly that the Medicaid program has "strong roots" in the "public welfare system."[20] The medical payments offered under Medicaid and its predecessor programs have always been linked to the recipients' confirmed status as "needy."[21] At first, mere poverty was sufficient to qualify one for Medicaid eligibility. In 1950, the first Federal public assistance for medical payments provided matching funds to health care vendors (i.e., providers), but only for people who were receiving cash welfare payments.[22] Later, in 1960, when the Kerr-Mills legislation, Medicaid's immediate predecessor, authorized Medical Assistance to the Aged, that program's eligible recipients were identified as the *indigent* elderly—not just the elderly. The replacement program was conceived of as a way to improve on the Kerr-Mills program which had become an embarrassment because it fell far short of meeting the basic medical needs of the elderly. However, poverty was required to justify eligibility even for the elderly.[23]

Like its predecessor, the Kerr-Mills program, Medicaid was designed by its proponents to ensure that low-income people received at least basic medical care. Health care, it was thought, should not be denied to anyone simply because they could not pay. This notion of medical egalitarianism did not seek to make everyone equal recipients of the same health care or beneficiaries of the same health outcomes. Instead, Medicaid began as traditional health insurance for poor people who fell into identified categories of need.[24] At its inception, it was an add-on to cash welfare benefit, covering very low income single parents and their children, the aged, blind, and disabled.[25] The point was to distribute medical care to those who could not afford to pay for it themselves but nevertheless were entitled to receive care on the basis of their incapacity. Thus, the program was driven by the communitarian principle of shared responsibility for the neediest among us. As Medicaid's eligibility expanded steadily beyond its initial base, covering additional populations such as children with two parents and pregnant women, its egalitarian motivations were tested. Lawmakers sought to define eligibility criteria that seemed fair. Analyst Alan Weil explains Medicaid's egalitarian function this way:

20. Judith D. Moore & David G. Smith, *Legislating Medicaid: Considering Medicaid and Its Origins*, HEALTH CARE FINANCING REV., Winter 2005, at 45, 45.

21. *Id.*

22. *Id.*

23. *Id.* at 46.

24. Rudowitz et al., *supra* note 10, at 1.

25. Alan Weil, *There's Something About Medicaid*, HEALTH AFF., Jan.–Feb. 2003, at 13, 16.

> If money is at the heart of debates over Medicaid, the millions of indigent people whose varied and complex medical needs are met by the program are its soul. The amount of human suffering the program alleviates is immense. In the absence of a comprehensive health care system that meets the acute and chronic care needs of the nation, Medicaid perfectly fits the metaphor of the "safety net."[26]

Arguably, a conceptual misunderstanding of the nature of poverty was one of the reasons the "safety net" metaphor has frayed. At the beginning of the program, policymakers constructed a program that was designed to help people on a temporary basis; it was thought that the Medicaid safety-net could provide quick fix to poverty and return families to live unsupported in the general economy. Instead, the program's costs continued to climb as it became clear that needs of covered individuals persisted as long as the complex structures that reinforce poverty, such as mis-education, under-employment, and inadequate housing, persisted.[27] Therefore, the Medicaid dollar became a less effective remedy for needy populations and thus became subject to selectively allocating benefits among competing, needy populations. Policymakers faced the perplexing conundrum of determining who was deserving of Medicaid eligibility and who was not.[28] The debate also shifted to identifying what services should be covered and which should not. Initially, Medicaid was a program to provide just one item in the safety net: medical care. It provided medical care to poor families with children, to the elderly, and to the disabled.[29] Congress tied Medicaid eligibility to receipt of cash assistance under welfare (Aid to Families with Dependent Children [AFDC]) or Supplemental Security Income (SSI) for the elderly and disabled (noncash recipients).[30] Over time, poverty alone became a less satisfactory criterion for Medicaid eligibility as policymakers recognized that poverty alone did not define neediness. Funds shifted away from covering only the poor to also covering the chronically ill and elderly. During this shift, Medicaid eligibility expanded to cover selected non-poor members of society, but the program covered this expansion by excluding some low-income recipients who were neither ill nor elderly.[31] In other words, Medicaid contained costs by covering only the *very* poor, but not those whose poverty did not place them at the very lowest economic strata. By 1985, the program reimbursed medical care for only forty percent of those below the federal poverty level, revealing that the philanthropically motivated soul of

26. *Id.* at 14–15.

27. *See* John Holahan et al., *Explaining the Recent Growth in Medicaid Spending*, HEALTH AFF., Fall 1993, at 177, 177, 183–85.

28. *See* Moore & Smith, *supra* note 20, at 45.

29. *Id.* at 49.

30. Rudowitz et al., *supra* note 10, at 2.

31. Brian O. Burwell & Marilyn P. Rymer, *Trends in Medicaid Eligibility: 1975 to 1985*, HEALTH AFF., Winter 1987, at 30, 31–33.

Medicaid had grown less compelled to address health needs due to mere poverty, than health needs due to frailty.[32]

The soul of Medicaid has also been challenged by federalism concerns. Stakeholders committed to minimizing the federal government's intrusion into health policy, while protecting states' control over their health care systems, have been outspoken opponents of the Medicaid program from the beginning. These opponents included the majority of physicians, hospitals, and health care providers.[33] The American Medical Association (AMA) wrote the following about the earliest, most limited versions of Medicaid proposed in 1956:

> The American Medical Association is vigorously and firmly opposed to this step. First, we see no need for the establishment of medical care as a fifth and separate category of Federal aid in public assistance programs. Pooling arrangements now available to the States under the existing program can accomplish more flexibly and less dangerously all the new proposals seek.[34]

The AMA, by this argument seemed to assert that the soul of Medicaid was to serve patient safety and perhaps state and local government autonomy. However, closer examination of the examples the AMA summoned in support of its federalism position quickly reveal that the providers' concerns went far beyond patient needs or states' rights. At bottom, it appears from their rhetoric, that the AMA's expressed concerns were driven first by the conviction that the soul of Medicaid was subordinate to the professional (and financial) interests of health care providers.

> [S]uch a new program would burden the community with regulations and restrictions inconsistent with local problems, local laws, or local customs. As an example, amendments to the aid-to-blind program under the Social Security Act have granted to optometrists since 1952 the privilege of diagnosing pathological conditions of the eye. This privilege, until 1952, had been uniformly denied to them by state licensure laws.[35]

Where providers were concerned, it seems the Medicaid program was beholden to protect the privilege of some health professionals as against others. Moreover, these providers appeared not only to object vigorously to the federal intrusion upon their profession, but also espoused a particular view of the proper extent and duration of neediness. Before its enactment, the AMA declared itself

> vigorously opposed to the proposed changes in the medical care provisions of the public assistance sections of the Social Security Act. We are opposed to those changes because they are needless, wasteful, dangerous, and contrary to

32. *See generally id.* at 30.

33. Edward Berkowitz, *Medicare and Medicaid: The Past as Prologue*, HEALTH CARE FINANCING REV., Spring 2008, at 81, 82.

34. Cohen, *supra* note 5, at 4.

35. *Id.*

> the established policy of gradual Federal withdrawal from local public assistance programs.[36]

Finally, the AMA's opposition made clear that in its view, the soul of Medicaid must be protected from a creeping philosophy of universal insurance. Many saw this as an idea born of socialist ideology, and contrary to the interests of the medical industrial complex and American values:[37]

> [W]e cannot escape the conclusion that injection of medical care as a separately matched category of expenditure under public assistance is only a forerunner to the injection of medical care as a categorical benefit under old age and survivors insurance. You are aware of the overwhelming rejection by both the American people and the medical profession of this philosophy. As physicians, we must continue to oppose programs which, in the guise of improving medical care, will lead to the destruction of the system which has produced the best medical care ever enjoyed by any people.[38]

At the outset, the ideals Medicaid's proponents sought to serve—to equally distribute access to health care to both wealthy and low-wealth individuals—conflicted with its opponents' goals of professional autonomy, federalism, and the propriety of offering long-term assistance to non-disabled, needy adults. As a result, the egalitarian goals of the Medicaid program have been tested and limited by the effort to identify just who are the "deserving poor" for whom federal assistance could be considered just. As Professor Nicole Huberfield ably explains, Medicaid's notion of the "deserving poor" meant those whose poverty could be considered "blameless" in that the condition was unavoidable.[39] Professor David Orentlicher explains that Medicaid assistance was initially limited to those who "could not be labeled social deviates or paupers by choice," and those who were made dependent through "no fault of their own."[40] Professor Sidney Watson offers this keen historical insight: the roots of this attitude lie in Elizabethan Poor Laws that informed the colonial belief that in general, poverty, disability, and illness were the result of individual moral failings.[41] Under these English precursors to American welfare law, the public assumed responsibility only for the poor who were not employable, rogues, vagabonds, vagrants, or possessed of relatives who could be made responsible for their destitution,

36. *Id.*

37. Arnold S. Relman, *The New Medical-Industrial Complex*, 303 NEW ENG. J. MED. 963, 963–70 (1980). *See generally* Max J. Skidmore, *Ronald Reagan and "Operation Coffeecup": A Hidden Episode in American Political History*, J. AM. CULTURE, Fall 1989, at 89, 89–96.

38. Cohen, *supra* note 5, at 4.

39. Nicole Huberfeld & Jessica L. Roberts, *Health Care and the Myth of Self-Reliance,* 57 BOS. C. L. REV. 1, 12 (2016).

40. David Orentlicher, *Medicaid at 50: No Longer Limited to the "Deserving" Poor?*, 15 YALE J. HEALTH POL'Y L. & ETHICS 185, 185–86 (2015).

41. Sidney D. Watson, *From Almshouses to Nursing Homes and Community Care: Lessons from Medicaid's History*, 26 GA. ST. U. L. REV. 937, 940 (2010).

though special collective provision was made for poor soldiers, mariners, and prisoners.[42] Communities were responsible for paupers within their local settlement, but not for those who were not local.[43] It is no surprise, therefore, that Medicaid, even at the beginning of the program, reached only half of the nation's indigent. From the start, what may be termed a "personal responsibility view of justice has operated in tension with the goals of egalitarian justice in competing for the soul of the Medicaid program.

III. LIBERTARIAN JUSTICE: MEDICAID WORK REQUIREMENTS

Philosophers do not present a single, agreed upon description of the tenants of libertarian justice. Instead, they describe the versions of the theory that are "most thoroughly worked out,"[44] and those views substitute for a cohesive conceptual consensus. The libertarian perspective on justice is organized around the alleged "natural right" to "life, liberty and property." The important premise seems to be that libertarianism protects individual liberty by protecting against unjust transfers of property generally, and most definitively prohibits governmental interference with individual liberty by the transfer property from one person to another.[45] Libertarian justice does, however, make room for the state to provide for those who suffer catastrophic contingencies that are not the result of natural bad luck, but are outcomes caused by others who have worsened conditions for the poor such that they have fallen below an acceptable societal baseline condition.[46] The general premise, then, is that no one should worsen the situation of others, and all should be left to live in the state that naturally occurs, absent disruption that harms others. Fredrick Hayek was a champion of libertarian justice. Hayek posited not only that egalitarian social justice was a vacuous "mirage," but asserted it was a dangerous view that could lead to the destruction of personal freedom.[47] Hayek was concerned with justice insofar as it affected how people treat one another in a market economy where all are free to use their knowledge for their own purposes.[48]

42. Jacobus tenBroek, *California's Dual System of Family Law: Its Origin, Development, and Present Status: Part I*, 16 STAN. L. REV. 257, 259 (1964).

43. *Id.* at 263.

44. Robert Elliot, *Future Generations, Locke's Proviso and Libertarian Justice*, 3 J. APPLIED PHIL. 217, 217 (1986).

45. Carl Watner, *The Proprietary Theory of Justice in the Libertarian Tradition*, 6 J. LIBERTARIAN STUD. 289, 289–90 (1982).

46. Elliot, *supra* note 44, at 220.

47. 2 FRIEDRICH A. HAYEK, LAW, LEGISLATION AND LIBERTY, THE MIRAGE OF SOCIAL JUSTICE 97–99 (1976).

48. *See* Andrew Lister, *The 'Mirage' of Social Justice: Hayek Against (and for) Rawls* 9 (Ctr. for the Study of Soc. Justice: Dep't of Politics & Int'l Relations, Univ. of Oxford, Working Paper No. SJ017, 2011).

Applied to Medicaid, the libertarian view of justice questions whether government sponsored redistribution of resources to the poor is just, or truly in the service of the common good.[49] As a policy matter, Medicaid work requirements represent an example of this view of justice because they minimize the extent to which government interferes with the property rights of non-needy individuals, by restricting transfer payments to those who are not only poor, but also unable to work. In the libertarian framework, justice is furthered by abstaining from reallocating what belongs to others and by "doing no harm to those who do not harm."[50] Applied to the Medicaid context, work requirements serve the libertarian tradition of justice. In contrast to the egalitarian view that the justice involves ensuring equal access to the right to health care, the libertarian view favors an absolute right to avoid redistribution.[51] Under the latter view, the interference of ownership title in funds must be protected from what libertarians would regard as an "unjustified coercion"—any government-sponsored effort to collect wealth and income, for reallocating to another, instead of leaving to each what belongs to him.[52]

On January 11, 2018, CMS issued a letter to state Medicaid directors providing a new Guidance document and soliciting input on Section 1115 waiver proposals that would impose work requirements (referred to as "community engagement") in Medicaid as a condition of eligibility.[53] The guidance described the potential scope of requirements that could be approved and presents the case for how these policies promote the objectives of the Medicaid program.[54] This action reversed previous positions of both Democratic and Republican administrations "which had not approved such waiver requests on the basis that such provisions would not further the program's purposes of promoting health coverage and access."[55] They asserted that such provisions would promote program objectives by helping states "in their efforts to improve Medicaid enrollee health and well-being through incentivizing work and community engagement."[56] President Trump subsequently issued Executive Order 13828 on April 10, 2018, ordering several federal agencies to enforce existing work

49. HAYEK, *supra* note 47, at 2.

50. Watner, *supra* note 45, at 290.

51. *See id.* at 293.

52. *Libertarianism*, STAN. ENCYCLOPEDIA PHIL. (2019), https://plato.stanford.edu/entries/libertarianism.

53. *See generally* Ctr. for Medicare & Medicaid Servs., Opinion Letter on Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries (Jan. 11, 2018).

54. *Id.*

55. Elizabeth Hinton et al., *Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers*, KAISER FAM. FOUND. 2 (Feb. 12, 2019), http://files.kff.org/attachment/Issue-Brief-Section-1115-Medicaid-Demonstration-Waivers-The-Current-Landscape-of-Approved-and-Pending-Waivers.

56. Ctr. for Medicare & Medicaid Servs., *supra* note 53.

requirements for Medicaid and develop new work programs.[57] On March 27, 2019, Judge James E. Boasberg of the Federal District Court for the District of Columbia "rejected for a second time Kentucky's attempt to require recipients to work or volunteer as a condition of coverage and blocked a similar rule in Arkansas, which has resulted in more than 18,000 people losing coverage since last summer."[58] Nevertheless, the number of states enacting Medicaid work requirements continues to grow, in no small part due to the appeal these requirements have to the libertarian notions of justice.

Figure 1
Work Requirement Waivers: Approved and Pending (December 2019)[59]
Source: Kaiser Family Foundation

Location	Waiver Status	Expansion Adults	Traditional Adults	Age Exemptions	Hours Required
Kentucky [4]	Set Aside by Court	X	X	65+	80/month
Michigan [5]	Approved/Not Implemented	X		63+	80/month
Mississippi [6]	Pending		X (parents 0-27% FPL)	65+	20/week
Montana	Pending	X		>55	80/month
New Hampshire [7]	Set Aside by Court	X		65+	100/month
Ohio	Approved/Not Implemented	X		50+	80/month
Oklahoma	Pending		X (parents 0-45% FPL)	>50	Ramps up to 20/week
South Carolina [8]	Pending		X (parents 0-100% FPL)	65+	80/month (quarterly average)
South Dakota [9]	Pending		X (parents 0-50% FPL, in Minnehaha or Pennington County)	60+	80/month or achieve monthly milestones in individualized plan
Tennessee	Pending		X (parents 0-98% FPL)	65+	20/week average
Utah [10]	Approved/Not Implemented		X (parents 60-100% FPL and childless adults 0-100% FPL)	60+	No "hour" requirement; specified job search/training activities required unless working 30/week
Virginia	Pending	X	X	65+	Ramps up to 80/month
Wisconsin	Approved/Not Implemented		X (childless adults 0-100% FPL)	50+	80/month

Objections to these work requirements begin with the evidence that most Medicaid recipients already work, making the requirement largely unnecessary but for its symbolic value. Some sixty-five percent of men on Medicaid are

57. Exec. Order No. 13,828, 83 Fed. Reg. 72, 15941–15944 (Apr. 10, 2018).

58. Abby Goodnough, *Judge Blocks Medicaid Work Requirements in Arkansas and Kentucky*, N.Y. TIMES (Mar. 27, 2019), https://www.nytimes.com/2019/03/27/health/medicaid-work-requirement.html.

59. *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, KAISER FAM. FOUND. (Jan. 16, 2020), https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/.

working, while fifty-six percent of women are employed.[60] Enrollees who live in the South are less likely to hold jobs than those in other regions, but rates were similar in rural and urban areas across all states.[61] Most Medicaid enrollees who work are working full-time for the full year, but their annual incomes are still low enough to qualify for Medicaid.[62] "Not surprisingly, the more education a recipient has, the more likely they are to be employed. About half of those who did not finish high school have jobs, but nearly 70% of those with at least a bachelor's degree do."[63] In families that include nonelderly Medicaid recipients, sixty percent have at least one full time worker, fourteen percent have at least one part time worker, and only twenty-one percent of families have no workers.[64] Importantly, thirty-six percent of those who do not work are ill or disabled, and an additional thirty percent are taking care of children or disabled family members.[65] Thus, the actual number of Medicaid recipients who have the capacity to work but do not is negligible.

A second category of critiques of work requirements is aimed at preventing harms to specific sub-populations. For example, veterans' groups argue those with complex health needs, chronic disabilities, and those experiencing homelessness will be harmed by work requirements.[66] Similar objections are raised on behalf of rural residents,[67] children, women, American Indians, Alaska Natives, and people with mental health conditions.[68] These populations will lose access to medical care more quickly though they have limited ability to meet the logistical rules that accompany the requirements such as reporting work status or volunteer hours to the state.

Proponents of work requirements advocate for work requirements as a "screening" mechanism, to direct the transfer of public funds toward only those

60. Tami Luhby, *Millions of Medicaid Recipients Already Work*, CNN (Jan. 10, 2018), https://money.cnn.com/2018/01/10/news/economy/medicaid-work-requirement/index.html.

61. *Id.*

62. *Id.*

63. *Id.*

64. Rachel Garfield et al., *Understanding the Intersection of Medicaid and Work*, KAISER FAM. FOUND. 2 (2018), http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work.

65. *Id.* at 4 fig.

66. *Taking Away Medicaid for Not Meeting Work Requirements Harms Veterans*, CTR. ON BUDGET & POL'Y PRIORITIES 1–2 (2019), https://www.cbpp.org/sites/default/files/atoms/files/11-8-18-health.pdf.

67. *See Taking Away Medicaid for Not Meeting Work Requirements Harms Rural Residents and Communities*, CTR. ON BUDGET & POL'Y PRIORITIES 1 (2019), https://www.cbpp.org/sites/default/files/atoms/files/8-22-18health.pdf.

68. *See generally Medicaid Briefs: Who Is Harmed by Work Requirements?*, CTR. ON BUDGET & POL'Y PRIORITIES (2019), https://www.cbpp.org/medicaid-briefs-who-is-harmed-by-work-requirements. *E.g.*, *Taking Away Medicaid for Not Meeting Work Requirements Harms Children*, CTR. ON BUDGET & POL'Y PRIORITIES 1 (2019), https://www.cbpp.org/sites/default/files/atoms/files/4-4-18health.pdf.

who are "truly needy."[69] They describe Medicaid as a "hand up" rather than a "hand out." Moreover, proponents advance a deterrent argument for work requirements that focuses on a particular view of poverty. According to economists Timothy Besley and Stephen Coate:

> The deterrent argument for work requirements focuses on the origins of poverty. Are individuals poor just because they have experienced bad luck or because of choices made earlier in life? If the latter is true, then public assistance may lead individuals to make choices that increase the likelihood that they will have to draw on such support in future.[70]

Both the deterrent and screening arguments that favor work requirements align squarely with libertarian justice principles.[71] Whatever the motivation, a total of "18,164 individuals lost coverage in 2018 due to failure to meet the work and reporting requirements, and few have regained coverage in 2019."[72] In February 2019, for example, almost five percent (10,854) of all Arkansas Works enrollees "had their cases closed for reasons other than failure to meet the work and reporting requirements."[73] When considering what justice demands of the Medicaid program, a key lesson to take-away from the work requirements debate is that a commitment to achieving justice equally motivates the opponents and proponents of Medicaid.

IV. UTILITARIAN JUSTICE: EFFORTS AND THREATS TO MAXIMIZING MEDICAID'S IMPACT

Utilitarianism is the ethical tradition that holds "that action is best, which procures the greatest happiness for the greatest numbers." Utilitarian justice aims to produce the greatest net sum of happiness for society overall.[74] When applied to health care, the goal becomes achieving the maximum overall health of the population, but utilitarianism can imply several variants on the exact method to achieve the desired maximization. For example, one approach could be to prioritize improving the health of the most destitute in society in order to yield the greatest overall gain to societal well-being.[75] Another approach to utilitarianism could be to express indifference toward any particular policy that benefits the health of the poor versus the rich in society, so long as the overall

69. Timothy Besley & Stephen Coate, *Workfare Versus Welfare: Incentive Arguments for Work Requirements in Poverty-Alleviation Programs*, 82 AM. ECON. REV. 249, 249 (1992).

70. *Id.* at 250.

71. *See id.*

72. Robin Rudowitz et al., *February State Data for Medicaid Work Requirements in Arkansas*, KAISER FAM. FOUND. 1 (2019), http://files.kff.org/attachment/State-Data-for-Medicaid-Work-Requirements-in-Arkansas.

73. *Id.* at 2.

74. JULIA DRIVER, *The History of Utilitarianism*, STAN. ENCYCLOPEDIA PHIL. (2014), https://plato.stanford.edu/entries/utilitarianism-history/.

75. Fabienne Peter, *Health Equity and Social Justice*, 18 J. APPLIED PHIL. 159, 163 (2001).

impact is to improve societal health generally.[76] Because utilitarian goals may be achieved independent of distributional concerns, some have criticized this perspective as "the folly of a simple-minded health benefit maximization approach to health policy."[77] Nevertheless, where Medicaid is concerned, utilitarian principles may seek to maximize the cost effectiveness of delivering health care rather than the health outcomes of Medicaid beneficiaries themselves. One Medicaid demonstration project that reflects a utilitarian view of justice is called "Money Follows the Person Rebalancing Demonstration" (MFP).[78]

The MFP Rebalancing Demonstration Grant was authorized by the Deficit Reduction Act of 2005 to help states increase the use of home and community-based rather than institutional long-term care services. This grant makes it easier for Medicaid funds to support delivery of high quality, long-term social service needs to seniors.[79] Recall that Medicaid is the nation's primary payor for long term services and supports for millions of low-income Americans. This may include payments to nursing homes, adult daycare programs, and home health aides, as well as assistance with transportation and employment.[80] Approximately twenty percent of all Medicaid payments go toward long-term care.[81] Therefore, the MFP program can be seen as Congress' utilitarian effort to help states rebalance their Medicaid long-term care systems, without regard for the wealth or poverty of beneficiaries. Forty-three states and D.C. participate in the demonstration. However, it has not been permanently funded,[82] and

76. *Id.* at 162.

77. MADISON POWERS & RUTH FADEN, SOCIAL JUSTICE: THE MORAL FOUNDATIONS OF PUBLIC HEALTH AND HEALTH POLICY 6 (2006).

78. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *Money Follows the Person*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html.

79. ERIC D. HARGAN, ACTING SEC'Y OF THE DEP'T OF HEALTH & HUMAN SERVS., REPORT TO THE PRESIDENT AND CONGRESS: THE MONEY FOLLOWS THE PERSON (MFP) REBALANCING DEMONSTRATION 2 (2017).

80. ERICA L. REAVES & MARYBETH MUSUMECI, MEDICAID AND LONG-TERM SERVICES AND SUPPORTS: A PRIMER 1 (2015).

81. Megan Thielking, *Trump Wants to Cut $800 Billion from Medicaid. Where Does all the Program's Money Go?*, STAT NEWS (May 22, 2017), https://www.statnews.com/2017/05/22/medicaid-spending-breakdown/.

82. HARGAN, *supra* note 79. The MFP Project was first authorized by the Deficit Reduction Act of 2005 and was extended through Fiscal Year 2016 by the Affordable Care Act, although some states were able to continue to use their existing grant funds through 2020. *Id.* at 1. On January 24, 2019, Congress signed the Medicaid Extenders Act of 2019 into law, extending funding for MFP project for an additional three months ($112 million). Medicaid Extenders Act of 2019, Pub. L. No. 116-3, 133 Stat. 6 (2019). On March 26, 2019, the House unanimously passed H.R. 1839, the Medicaid Services Investment and Accountability Act of 2019, which would add additional short-term funding to the MFP program to fully fund it through September 2019 and would extend the expiring spousal impoverishment protections for people receiving HCBS through September

Congress has no data to evaluate the program's effectiveness.[83] This particular shortcoming in the MFP program—its lack of concrete evidence to evaluate the program's effectiveness—is emblematic of a major reason that Medicaid is widely perceived to have fallen short of its justice goals from a utilitarian perspective.

Another primary threat to meeting utilitarian goals is the Medicaid program's insufficient reimbursement rates. Data from a 2017 RAND survey provide an overview of the empirical literature that show ninety percent of surveyed providers cite "low reimbursement" as a key driver in their decision to avoid or reduce their level of participation in the Medicaid program, a finding that is "consistent with related studies conducted over the past [thirty] years."[84] Other issues around reimbursement are also frequently cited as factors that discourage Medicaid participation, including "delayed reimbursement, high administrative burden associated with enrollment and billing processes, and lower reimbursements for nurse practitioners and physician assistants relative to physicians."[85] The average Medicaid payment rate for primary care services in 2012 was lower than the Medicare rate in forty-eight states and the District of Columbia and represented an average of approximately fifty-nine percent.[86]

A further threat grows out of Medicaid's low reimbursement rates, which limits the level of physician participation in the program and thus compromises Medicaid's ability to reach a maximum number of potential beneficiaries.[87] "In 2013, most office-based physicians (95.3%) [were accepting] new patients. The percentage of physicians accepting new Medicaid patients (68.9%) was lower than the percentage accepting new Medicare patients (83.7%) or new privately insured patients (84.7%)."[88] At that time, specialists were accepting new

2019. Medicaid Services Investment and Accountability Act of 2019, Pub. L. No. 116-16, 144 Stat. 852 (2019). Another bill, the EMPOWER Care Act, has also been introduced and would reauthorize MFP for five years. H.R. 1342, 116th Cong. (1st Sess. 2019); S.B. 548, 116th Cong. (1st Sess. 2019).

83. HARGAN, *supra* note 79, at 19–27.

84. JUSTIN W. TIMBIE ET AL., EXAMINING THE IMPLEMENTATION OF THE MEDICAID PRIMARY CARE PAYMENT INCREASE 1 (2017).

85. *Id.*

86. Stephen Zuckerman et al., *How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees*, KAISER FAM. FOUND. 2, 8 (2012), https://www.kff.org/wp-content/uploads/2013/01/8398.pdf.

87. *See* David Baugh & Shinu Verghese, *Physician Service Use and Participation in Medicaid, 2009*, MATHEMATICA 1, 9 (2012), https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/MAX_IB11_PhysicianParticipation.pdf.

88. Esther Hing et al., *Acceptance of New Patients with Public and Private Insurance by Office-based Physicians: United States, 2013*, CTRS. FOR DISEASE CONTROL & PREVENTION 6 (2015), https://www.cdc.gov/nchs/data/databriefs/db195.pdf.

Medicaid patients more readily than primary care physicians.[89] "Physician participation in Medicaid is generally highest in the most rural states. In the 11 states where at least half the population lives in rural areas, the median Medicaid physician participation rate is 90%, compared to 71% in the 25 states where less than one-quarter of the population is rural."[90] However, the percentage of physicians accepting new Medicaid patients varied by state, ranging from thirty-nine percent in New Jersey to ninety-seven percent in Nebraska.[91]

Another threat to Medicaid's ability to maximize health outcomes overall is the extent to which the program suffers from fraud and waste. In Fiscal Year 2017 alone, improper payments—which include things like payment for non-covered services or for services that were billed but not provided—totaled more than thirty-six billion dollars.[92] It is estimated that fifty-four percent of the improper payments were the result of states not screening or enrolling providers as they are required to do.[93] (State Medicaid agencies are required to screen providers before enrolling them in the program and revalidate providers enrolled in the program every five years; the purpose of these requirements, which also apply to Medicare and CHIP, is to keep out bad actors who put beneficiaries and program funds at risk.[94]) Another estimated thirty-one percent of Medicaid improper payments were attributable to eligibility errors. In addition, some states have been found to engage in exploitive practices to increase federal matching funds. For example, in Pennsylvania, a state tax on Medicaid managed care plans was used to draw down an additional one billion dollars over three years.[95]

Medicaid critics capitalize on the potential *utilitarian injustice* of the program. The story goes that Medicaid weakens the fabric and ethic of our overall economy by using funds to pay some for what others have to work to receive. The notion that Medicaid might be paying for people who are "gaming the system" while others work hard to succeed within the system depends on portraying the program as welfare for the exploitative. This was the meaning

89. Sandra L. Decker, *Two-Thirds of Primary Care Physicians Accepted New Medicaid Patients in 2011-12: A Baseline to Measure Future Acceptance Rates*, 32 HEALTH AFF. 1183, 1185 (2013).

90. Julia Paradise, *Data Note: A Large Majority of Physicians Participate in Medicaid*, KAISER FAM. FOUND. 1 (2017), http://files.kff.org/attachment/Data-Note-A-Large-Majority-of-Physicians-Participate-in-Medicaid.

91. *Id.* at 1.

92. Andy Schneider, *How to Reduce Improper Payments in Medicaid*, GEO. U. HEALTH POL'Y INST. (Apr. 19, 2018), https://ccf.georgetown.edu/2018/04/19/measuring-medicaids-mistakes-estimating-improper-payments/.

93. *Id.*

94. *Id.*

95. DANIEL R. LEVINSON, DEP'T OF HEALTH & HUMAN SERVS., PENNSYLVANIA'S GROSS RECEIPTS TAX ON MEDICAID MANAGED CARE ORGANIZATIONS APPEARS TO BE AN IMPERMISSIBLE HEALTH-CARE-RELATED TAX 9 (2014).

behind constructing the tale of the "Welfare Queen."[96] This was an effort to build a caricature (albeit built on a single real person's story) in order to associate Medicaid with a person who combines one part sloth with two parts slick to manipulate the American government into paying for what others must work to achieve.[97] These are not the people who are Medicaid recipients; once again, the data show that sixty-three percent of Medicaid enrollees work; eleven percent of those not working are ill or disabled, twelve percent are primary care-givers, and seven percent are attending school.[98]

Notwithstanding its shortcomings, or the perspective from which it is viewed, the Medicaid program remains the most important program in the nation in the effort to achieve health justice. The Association of State and Territorial Health Officials recently put it this way: "Medicaid is uniquely positioned to enhance public health efforts as it is the largest source of coverage for low income and vulnerable individuals who experience the greatest health disparities."[99] Because of the population that it reaches and its inherent flexibility, Medicaid remains the most important program in the nation's effort to achieve health equity.

The final section of this article presents a proposal that rests on this view. It proposes that in light of the size of the Medicaid program, and its service to the precise population most affected by health inequity, the Medicaid program is ideally suited to apply its flexibility to achieve the social justice aims of public health. The next section of this article argues that Medicaid is the nation's weapon of choice in the fight for population health equity and equitable justice.

V. EQUITABLE JUSTICE: MEDICAID AND THE SOCIAL DETERMINANTS OF HEALTH

The most recent and comprehensive explication of the justice aims for public health has been advanced by Madison Powers and Ruth Faden.[100] Their framework recognizes justice as an "inherently remedial task" and therefore assumes no ideal distributional starting point.[101] Instead, in an intensely pragmatic fashion, Powers and Faden lay out a theory of social justice that adds several important concepts required to serve the justice objectives that lie at the

96. *See 'Welfare Queen' Becomes Issue in Reagan Campaign*, N.Y. TIMES (Feb. 15, 1976), https://www.nytimes.com/1976/02/15/archives/welfare-queen-becomes-issue-in-reagan-campaign-hitting-a-nerve-now.html.

97. *Id.*

98. *See* Garfield et al., *supra* note 64.

99. Noelle Andrade & Emily Moore, *Maximizing Medicaid-Public Health Partnerships*, ASTHO (Sept. 14, 2016), https://www.astho.org/StatePublicHealth/Maximizing-Medicaid-Public-Health-Partnerships/9-14-16/.

100. *See generally* POWERS & FADEN, *supra* note 77.

101. *See id.* at 5.

core of the Medicaid program.[102] First, the demands of justice for low-wealth communities extend beyond ensuring access to health care alone. The injustice that causes Medicaid populations to suffer inferior health outcomes is cumulative:

> [Q]uestions of justice emerge from the operation of the totality of social institutions, practices, and policies that both independently and in combination have the potential for profound and pervasive impact on human well-being in all of its essential aspects . . . . [Q]uestions about which inequalities matter most are comprehensible only by examining all of the social determinants having cumulative and interactive effects on human well-being . . . . Taken in tandem, they can reinforce and perpetuate clusters of disadvantage, and in the worst of possible scenarios, the cumulative disadvantages that emerge become nearly impossible to escape or avoid without heroic effort or extraordinary good luck.[103]

This insight is crucial to addressing the health needs of the low-wealth Medicaid population because it takes into account that eliminating unjustly poor health outcomes will require attention to those that are not attributable solely to the vectors of disease, illness, or injury.[104] Second, Powers and Faden teach us that unjust inequalities are both distributive and relational:

> [J]ustice is concerned with more than distributive principles. In addition, much of what justice comprehends lies beyond an assessment of each person's distributive shares . . . . For example, worries about social subordination and stigma, lack of respect, lack of institutions, and social practices that adequately support capacities for attachment and self-determination also are matters of justice—for both individuals and groups.[105]

This insight is fundamental to addressing the health needs of the low-wealth Medicaid population who continue to suffer egregious racial and ethnic health and health care disparities. Subordination—that is racial and ethnic discrimination—interact through multiple social determinants of health including housing, employment, education, environmental, and criminal justice inequality—to proximately produce widely disparate health and social outcomes for minority communities.[106] The Medicaid program is an appropriate mechanism to remedy this public health crisis for at least three important reasons.

102. *See generally id.* at 15–29.

103. *Id.* at 5.

104. *Id.* at 16–29. In fact, Powers and Faden advance a theory of justice that encompasses six essential and required features of well-being: health, personal security, reasoning, respect, attachment, and self-determination. POWERS & FADEN, *supra* note 77, at 6.

105. *Id.* at 6.

106. *See generally* Dayna Bowen Matthew, *Structural Inequality: The Greatest Threat to America's Health and How the Affordable Care Act Can Help*, GEO. L.J. (forthcoming 2020) (on file with author).

First, Medicaid touches the very population that is most in need of health justice. Medicaid provides health insurance coverage to more people than any other single program in the United States, with coverage for low-income children, adults, seniors, and those with disabilities. As of March 2017, there were seventy-four million Medicaid and CHIP enrollees, of which thirty-six million were enrolled in CHIP or were children enrolled in Medicaid, according to the Centers for Medicare and Medicaid Services.[107] These families are overwhelmingly poor; sixty-one percent of Medicaid's non-elderly beneficiaries are below 100% of the Federal poverty level and eighty-three percent of enrolled children are in that low-income bracket.[108]

Second, the Medicaid program has the inherent flexibility that could meaningfully extend to finance social drivers of health outcomes if (and this is a very big contingency) the program were adequately funded to do so.[109] Already, many states are experimenting with demonstration projects using Section 1115 waivers to fund interventions aimed at improving access to and quality of the social determinants of health for low-wealth communities. For example, CMS approved North Carolina's "Healthy Opportunity Pilot" Section 1115 waiver in October 2018.[110] The waiver provides the North Carolina Department of Health and Human Services (DHHS) authority to transition its fee-for-service delivery system to a managed care program and, as part of the transition, important flexibility to implement a groundbreaking pilot program in select regions. Through this program, the state will invest $650 million in Medicaid funding to promote value through evidence-based interventions designed to address non-medical factors that drive health outcomes and costs. "The Healthy Opportunities Pilots will provide evidence-based interventions to address housing, food, transportation, interpersonal violence and toxic stress for Medicaid-enrolled pregnant women, children and adults who meet certain eligibility criteria."[111] Healthy Opportunity Pilot participants

> must have at least one physical or behavioral health risk factor (e.g., multiple chronic conditions or history of a poor birth outcome) and at least one social risk factor (e.g., homelessness/housing insecurity or food insecurity)—as defined by DHHS. Each pilot must address all domains of need (housing, food,

107. *State Health Facts Data: Monthly Child Enrollment in Medicaid and CHIP*, *supra* note 19.

108. Rudowitz et al., *supra* note 10, at 4 fig.

109. *E.g.*, Karen DeSalvo & Michael O. Leavitt, *For an Option to Address Social Determinants of Health, Look to Medicaid*, HEALTH AFF. (July 8, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190701.764626/full/.

110. *See Proposed Program Design: Section 1115 Demonstration Waiver*, N.C. DEP'T HEALTH & HUM. SERV., https://www.ncdhhs.gov/assistance/medicaid-transformation/proposed-program-design (last visited Jan. 19, 2020).

111. N.C. DEP'T OF HEALTH & HUMAN SERVS., HEALTHY OPPORTUNITIES PILOTS FACT SHEET 1, 3 (2018).

> transportation, interpersonal violence and toxic stress) for all types of eligible beneficiaries (pregnant women, children and adults).[112]

In another example of Medicaid's flexibility, Louisiana's Department of Health partnered with the state's Housing Authority to braid funding in a Permanent Supportive Housing (PSH) program for disabled populations. These funds included Community Development Block Grant, disaster recovery funds, Federal Rental Assistance (e.g., Housing Choice Vouchers, Section 811 Project Rental Assistance), and Low-Income Housing Tax Credits.[113] The Louisiana PSH program

> links affordable rental housing with voluntary, flexible, and individualized services to people with severe and complex disabilities, enabling them to live successfully in the community. After Hurricanes Katrina and Rita, advocates for both people with disabilities and homeless people, along with consumers, service providers, with state/local governmental agencies formed a successful partnership that resulted in the development of over 3,000 units of permanent supportive housing for extremely low income people with disabilities.[114]

Preliminary data from the Louisiana Department of Health show the PSH program is getting results. PSH participants' emergency department usage is down by almost twenty-five percent, and overall hospitalizations are down.[115] In an independent study for the years 2011–2012, PSH saw a twenty-four percent reduction in Medicaid costs for housed beneficiaries and ninety-five percent of those who were previously homeless have remained housed since the program's inception.[116] Finally, the principles of equitable justice that are central to the Medicaid program demand that our society eradicate avoidable, non-clinically supportable racial, ethnic, and socioeconomic health disparities; this can only be done by embracing the cumulative, interactive, distributional, and relational aspects of health inequality in America. Louisiana and North Carolina are two examples that this approach is both possible and effective.

112. *Id.* at 3.

113. AMY CLARY & TINA KARTIKA, NAT'L ACAD. FOR STATE HEALTH POLICY, BRAIDING FUNDS TO HOUSE COMPLEX MEDICAID BENEFICIARIES: KEY POLICY LESSONS FROM LOUISIANA 1 (2017); LA. DEP'T OF HEALTH & HOSPS., LOUISIANA'S PERMANENT SUPPORTIVE HOUSING PROGRAM: A PARTNERSHIP BETWEEN THE DEPARTMENT OF HEALTH AND HOSPITALS AND THE LOUISIANA HOUSING CORPORATION 1 (2014).

114. *Permanent Supportive Housing (PSH)*, LA. DEP'T HEALTH, http://ldh.la.gov/index.cfm/page/1732 (last visited Jan. 18, 2020).

115. CTR. FOR HEALTH CARE STRATEGIES, INC., LINKING HOUSING AND HEALTH FOR SUSTAINABLE CROSS-DISABILITY SERVICE DELIVERY: LOUISIANA POST-KATRINA AND RITA 5 (2018).

116. *Id.*

VI. CONCLUSION

The struggle for the soul of Medicaid is not a recent story. But although some politicians and providers and payors may have struggled to identify the soul of the Medicaid program, the American public has not. For those who paid attention, the struggle for the soul of Medicaid was most recently and resoundingly won during the "Repeal and Replace" battle of 2017. Before Congress attempted over fifty times to eliminate the Medicaid expansion.[117] Still, seven in ten Americans (seventy-one percent) said they preferred "keeping Medicaid largely as it is," while fewer (twenty-six percent) supported changing Medicaid to limit federal spending and increase state flexibility with regard to eligibility and services covered under the program.[118] Despite the fact that most Americans favor placing conditions on Medicaid eligibility, the majority of those polled "support allowing states to impose work requirements for non-disabled adults (70 percent) and to require drug-testing (64 percent) for Medicaid beneficiaries."[119] Fewer support changes that are directed at restricting Medicaid for vulnerable populations like "stopping federal payments to Planned Parenthood for one year (30 percent), or limiting federal funding for Medicaid coverage of long-term care for seniors and people with disabilities (21 percent)."[120] Medicaid critics capitalize on the assumption that poverty—without some other accompanying tragedy—is a status that no one in America endures unless they do so by choice. In this article, I have argued this view is not only incorrect, but also a fundamental contradiction of the demands of fairness and equity—that version of justice that was the very soul of Medicaid in 1965, and remains so today.

117. Tessa Berenson, *Reminder: The House Voted to Repeal Obamacare More than 50 Times*, TIME (Mar. 24, 2017), https://time.com/4712725/ahca-house-repeal-votes-obamacare/.

118. *Data Note: 10 Charts About Public Opinion on Medicaid*, KAISER FAM. FOUND. (June 27, 2017), https://www.kff.org/medicaid/poll-finding/data-note-10-charts-about-public-opinion-on-medicaid/.

119. *Id.*

120. *Id.*