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DOI: 10.1377/hlthaff.2019.01463
HEALTH AFFAIRS 39,
NO. 3 (2020): 514–518

COMMENTARY

Closing The Medicaid Coverage Gap: Options For Reform

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ABSTRACT Eight years after the US Supreme Court's landmark decision in *National Federation of Independent Business v. Sebelius*, more than two million of the nation's poorest working-age adults continue to feel its effects. These are the people who, because of the decision, remain without a pathway to affordable health insurance coverage because they live in a state that has not expanded Medicaid under the Affordable Care Act (ACA). Closing the coverage gap created by *NFIB v. Sebelius* represents the ACA's most pressing piece of unfinished business. Several options, which vary in cost and political complexity, exist for closing the gap in ways that respect the ACA's pluralistic approach to insurance coverage while adhering to constitutional principles. These considerations must be balanced against the urgency of the problem and the fact that, constitutionally speaking, Medicaid alone can no longer guarantee a national remedy to the fundamental issue of health insurance inequality for the poorest Americans.

How to provide coverage for the very poorest Americans who remain ineligible for Medicaid but too poor for subsidized private health insurance—closing the Medicaid coverage gap—represents the biggest piece of unfinished business under the Affordable Care Act (ACA). Certain aspects of the ACA, such as its private insurance subsidy provisions, merit adjustment to correct flaws in their original design that have led to affordability problems. However, the Medicaid coverage gap is a consequence not of initial policy shortcomings but, instead, of the US Supreme Court's holding in *National Federation of Independent Business v. Sebelius*.[1] In its unprecedented decision, the Court ruled that Congress had exceeded its constitutional powers by conditioning federal Medicaid funding on states' willingness to expand eligibility to reach all poor adults, not just those eligible under traditional rules.

Ultimately, the Court's decision essentially preserved expansion as an eligibility option. But the decision also made provision of coverage for the poorest Americans a matter of state choice. Because the ACA's premium and cost-sharing subsidies for health insurance Marketplace policies don't commence until household income reaches 100 percent of the federal poverty level, millions of people have fallen into the coverage gap.

As of January 2020 fourteen states had not yet adopted the Medicaid expansion. Political leaders in Kansas struck an agreement to move forward early in the year, pending the approval of the entire legislature, and expansion happened by popular vote in three states—Utah, Nebraska, and Idaho.[2] Idaho's expansion began in January 2020,[3] and Nebraska anticipates that its expansion will start by October 2020.[4] But in the fourteen states that have yet to act,[5] over two million Americans remain without affordable coverage.[6]

Among all uninsured Americans—whose num-

ber topped twenty-seven million in 2018[7]—those falling into the coverage gap possess characteristics that underscore the need for a solution. By definition, they are exceptionally poor. The overwhelming majority are working or attending school, are caring for children or other family members, or have conditions that prevent them from working. Poor older adults within the gap group are in significantly worse health than their counterparts who do not have low incomes.[8] Because the states that have not yet expanded Medicaid are substantially southern, population demographics mean that the excluded population is disproportionately African American. Nonexpansion states also tend to have the highest poverty rates, the most serious population health burdens,[9] the highest overall uninsurance rates, and the most restrictive financial eligibility rules for traditional Medicaid. Four states alone—Florida, Georgia, North Carolina, and Texas—account for 68 percent of the gap population.

Fixing this problem would have a measurable impact on the nation's significant remaining uninsurance problem. The gap population includes one in nine uninsured Americans[10] and 20 percent of all uninsured adults with incomes low enough to qualify for Medicaid.[11] These are not trivial figures.

Beyond numbers, the group's very existence raises basic issues of fairness. People in the group remain uninsured not because they are unaware of benefits or simply have not applied for coverage. Rather, for completely unforeseeable reasons, they have been locked out: ineligible for traditional Medicaid despite their poverty, yet without access to affordable private insurance.

Strong health and social welfare arguments favor addressing the issue. Uninsured people are significantly more likely to forgo medical care because of cost and less likely to have a regular source of health care or access to routine health care or care when needed for serious health conditions.[12] Being uninsured is associated with higher mortality rates, particularly from preventable causes.[13]

Elevated uninsurance rates also affect the stability and performance of the broader health care system, particularly in medically underserved communities whose members face elevated poverty and health risks and a shortage of primary health care. For example, community health centers in nonexpansion states exhibit lower overall patient care capacity, offer fewer services, operate fewer sites, have smaller clinical staffs,[14] and are less likely to offer medication-assisted treatment in response to the opioid crisis.[15] Rural hospitals show greater financial distress in nonexpansion states.[16] If improving the efficiency of rural hospitals is a priority, doing so means addressing a core problem: unmanageable numbers of uninsured patients.

Expanding Medicaid also would help make private insurance more affordable. Federal researchers have concluded that Medicaid expansion reduces Marketplace plan premiums by about 7 percent, because of the financial impact on premiums associated with larger numbers of enrollees with very low incomes.[17] Were nonexpansion states to adopt the expansion, not only would over two million people gain access to insurance, but an estimated two million more who are now enrolled in subsidized Marketplace plans would qualify as well[6] —thereby reducing pressure on insurance costs.

Finally, the expansion's enhanced 90 percent federal contribution rate makes the additional cost of expanding relatively modest. One estimate places the added costs at 1 percent or less of a state's general fund, with offsets as a result of economic gains.[18]

What policy options might help address this problem? To be sure, future policy makers could elect to replace the ACA's entire coverage design—which builds on the nation's pluralistic, multipathway approach to coverage—with an alternative model. More market-oriented policy makers might move toward reforms that use lightly regulated individual private insurance policies for everyone without employer coverage. More progressive policy makers might instead move toward a unified federal public insurance program available either as a matter of choice or as a true successor to the current system. For the purposes of this article, however, we assumed that the public-private pluralism embodied in the ACA would remain the strategic choice and that policy makers would continue to favor approaches grounded in principles of shared federal-state governance (often termed "federalism") that preserve state choice.

The ACA's Two Federalism Models

In adhering to principles of federal-state power sharing, the ACA used two constitutionally permissible models on which so much of this nation's social welfare legislation rests.

The first federalism model, on which Medicaid and the Children's Health Insurance Program (CHIP) rest, relies on state participation to achieve national goals. States that elect not to participate can do so, and in the absence of state involvement, a national goal simply may not be met in that state. Indeed, Arizona remained without Medicaid for eighteen years.

NFIB v. Sebelius considerably broadened state power to keep traditional Medicaid program

funding while nonetheless refusing to move forward on a major expansion. As a result of the Court's decision, the federal government can offer states participation inducements. But it cannot condition funding for the traditional program on state participation in what the Court termed a "new" program. By identifying the ACA Medicaid expansion as "new" rather than simply the latest extension of Medicaid—paralleling coverage of all low-income children and pregnant women—the Court created a state option to forgo expansion while preserving eligibility for federal payments to support the traditional program.

The second federalism model, also found in the ACA, assumes and encourages state partnership. But the model also provides a federal backup system in the event of state nonparticipation. The ACA's insurance reforms and Marketplaces reflect this approach, which Congress chose to ensure that the reforms reached all residents nationally without limiting state choice. This approach preserves the constitutional federalism principles of shared power while ensuring that national goals are achieved.

Given the pressing nature of the coverage gap problem, we believe that both of these models—pure state choice, and state choice coupled with a federal backup system—merit consideration. In our view, Medicaid represents the stronger strategy for covering the poor. First, its unique attributes as an insurer mean that people can enroll when coverage is needed, and coverage can be established retroactively to guard against the denial of care before enrollment happens. Coverage is comprehensive, with nominal cost sharing.

Second, research also shows that dollar for dollar, Medicaid is the less costly solution. Indeed, the Congressional Budget Office estimated significantly higher federal per capita costs as a result of the *NFIB v. Sebelius* decision, which had the effect of moving adults with incomes of 100–138 percent of poverty from Medicaid into subsidized Marketplace insurance in nonexpansion states.[19]

Finally, Medicaid also has a high degree of consumer satisfaction. A recent Commonwealth Fund study found that in 2018, 62 percent of Americans with individual coverage rated their coverage good, very good, or excellent, compared to 84 percent of Americans with Medicaid.[8] Therefore, we emphasize the value of Medicaid solutions.

But should states continue to reject Medicaid expansion, there is an increasing imperative to consider other options—which inevitably raise additional cost or political concerns.

Medicaid Options To Encourage State Expansion

RESTORE THE ORIGINAL FINANCIAL INCENTIVES FOR NEWLY EXPANDING STATES The simplest option is one that numerous experts have identified: restore the original ACA rule that extended 100 percent federal funding during the first three years of expansion, to be followed by a slow reduction in federal funding to the 90 percent federal contribution level that applies in 2020 and beyond. Originally, the special 100 percent enhancement applied only from 2014 through 2016. Restoring this special rule for the remaining nonexpansion states would be a relatively straightforward and low-cost matter.

GIVE EXPANSION STATES ADDED FLEXIBILITY Numerous states have expressed interest in expanding eligibility for Medicaid to people with incomes of up to 100 percent of poverty, with low- and moderate-income people with incomes above the 100 percent threshold enrolled in subsidized Marketplace plans. Were such an option to be added, it would naturally need to be extended to all states, not only those that have not yet expanded Medicaid.

Adding such an option would raise several problematic issues. It would substantially increase the financial burdens faced by people with incomes of 100–138 percent of poverty, who would lose Medicaid's special enrollment and coverage protections. It would increase federal spending as a result of the higher per capita cost of Marketplace coverage. As discussed above, the option also would place additional pressure on premiums, as the number of people with very low incomes in the insurance pool grew.

We believe that although some current expansion states might decide to shift their populations in this manner, most would reject it for the reasons noted above: Medicaid makes sense, and moving away from Medicaid would lead to many spillover problems. In the end, the number of states that reduced coverage would be relatively modest, compared to the number of states that would adopt expansion.

Congress could take further steps to avert such a result by establishing additional incentives for states that continue to keep Medicaid coverage for people with incomes up to 138 percent of poverty. One such incentive might be a modest enhancement to the federal financial contribution rate for states' traditional Medicaid programs. This type of enhancement would be perfectly in alignment with the constitutional constraints imposed by *NFIB v. Sebelius*, since it would simply reward choice without penalizing states that did not choose to preserve a higher income eligibility threshold. A second enhancement might be additional federal sup-

port, modeled on the capped financing strategy used in Medicaid's disproportionate share hospital payment program, that would assist states with health system transformation efforts aimed at improving health care quality and efficiency and integrating health and social services. Again, this strategy would function as an inducement, not a penalty.

We believe that these enhancements for states that adopted and maintained Medicaid eligibility for adults with incomes up to 138 percent of poverty would preserve the constitutional principle established by *NFIB v. Sebelius*, since they would reward state choice. Of course, such a multifaceted enhancement strategy would carry significant costs, while adopting an overall approach that extended beyond simple enhancements for states that newly opted to expand Medicaid. In fact, however, the Medicaid expansion is an option in all states; therefore, incentives to maintain coverage without rolling back eligibility must be considered.

In the end, it is very difficult to estimate how many states would expand or how many would, if given the opportunity to do so, roll back coverage to a lower income eligibility threshold. Most efforts to predict how states would respond to Medicaid flexibility are rooted in uncertainty. For example, it is not evident who would have predicted that in a state as conservative as Idaho, a grassroots referendum would push expansion forward into state implementation. One might have predicted that by the end of 2019 a pragmatic North Carolina governor, like his Virginia counterpart in 2017, would have found a political path forward in collaboration with a conservative legislature. This has not happened yet. What is likely true, however, is that the case for adopting and maintaining Medicaid expansion is only strengthened with heightened rewards for doing so.

Beyond Medicaid Enhancement: A Federal Fallback

The consequences of *NFIB v. Sebelius* in an era in which some states remain implacably opposed to the Medicaid expansion raise a deeper issue: whether to create a federal coverage fallback, both for states that continue to refuse expansion and for those that might in the future reverse course, as they are permitted to do.

From a mechanical perspective, a federal fallback would be relatively simple, consisting of a zero-purchase premium for Marketplace coverage with full cost-sharing assistance. Of course, this option would lack Medicaid's unique and important attributes for the poor—its enrollment flexibility, retroactive eligibility feature, broad and comprehensive benefits, and low cost sharing. On a per capita basis, coverage would be significantly more costly to the federal government. Furthermore, depending on the private insurance market for the expansion population would draw crucial membership volume away from the current generation of state Medicaid managed care initiatives. In recent years many of these initiatives, which have flowed from the expansion itself, have taken on the difficult task of creating both comprehensive care systems that integrate coverage more directly into delivery and payment reform and innovative strategies to better use health care as an entry point for addressing broader health and social needs.

But the arguments for a fallback are equally strong from a health and social welfare perspective. Depriving more than two million of the nation's poorest people of any meaningful opportunity to have affordable insurance simply because of the state in which they live may honor the principle of state flexibility. In effect, however, the poor alone have been asked to pay the price exacted by a fundamental shift in constitutional federalism principles as a result of a decision without legal precedent. The central lesson of *NFIB v. Sebelius* is that solutions aimed at using Medicaid to achieve national priorities have limits. The program occupies a fundamental place in national health policy, and in the past it served as an effective means of advancing reforms nationwide through mandatory conditions of participation. *NFIB v. Sebelius* revealed the limits of this strategy.

Conclusion

We believe that Medicaid remains the preferred policy approach and that to counteract the effects of *NFIB v. Sebelius*, policy makers could combine a moderate increase in state flexibility with additional financial incentives. But to overcome health inequality nationwide, it may also be important to bring other solutions to bear to supplement what Medicaid might be able to achieve alone. In the end, this may be the strongest justification for additional and innovative options. ■

The authors thank the Commonwealth Fund for its support of the preparation of this article. Sara Rosenbaum thanks the Commonwealth Fund and George Washington University for their ongoing support. Gail Wilensky serves as a director of UnitedHealth Group.

NOTES

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