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The following is a policy memo written to U.S. Senate Minority Leader Chuck Schumer for Public Policy course *Wealth and Poverty*. This memo discusses the ways in which current federal policy falls short in ensuring equitable access to affordable healthcare through Medicaid, specifically focusing on the coverage gap created by states that did not expand Medicaid eligibility through the ACA. It then proposes two possible policy alternatives to alleviate this gap; analyzes each alternative based on the criteria of effectiveness, political feasibility, and administrative feasibility; and uses this analysis to make a recommendation.

To: U.S. Senate Minority Leader Chuck Schumer
From: Kristina Smelser
Subject: Alleviating the Coverage Gap in Medicaid Eligibility

Executive Summary

Millions of low-income Americans suffer from poor health due to the rise in healthcare costs, decline of employer-provided health insurance, and inadequacy of government programs. Specifically, numerous states have not expanded Medicaid eligibility to certain low-income residents as dictated by the ACA, resulting in a coverage gap that leaves millions of poor individuals without access to insurance through Medicaid or Marketplace subsidies. Thus, the proposed policies will be analyzed by: 1) their effectiveness in incentivizing states to expand Medicaid eligibility, 2) their political feasibility, and 3) their administrative feasibility. The first alternative policy will offer new healthcare program funding to all states, but at more attractive rates for expansion states; the second policy will penalize non-expansion states by reducing their state's federal Medicaid funding by 1%. Based on these criteria, Alternative 1 is the best option to address the coverage gap and expand healthcare coverage to more low-income Americans.

Problem Statement

Under our current system, too many low-income Americans cannot access affordable health care. 1 in 5 Americans in the bottom third of the income distribution have declined recommended medical treatment because of the cost, versus just 1 in 25 for the top third. As a result, Americans with incomes below $22,500 per year self-report poor or fair health at three

times the rate of those with incomes above $47,700 (Johnson). Despite the U.S. spending far more on healthcare than any other nation in the OECD, our average life expectancy is one of the lowest and most stratified by income (Reich 4/19). Policy intervention should aim to mitigate these health deficiencies and ensure the well-being of all Americans, regardless of their income.

U.S. healthcare costs are so high largely due to the recent consolidation of the insurance and pharmaceutical industries, within which a shrinking number of private, for-profit companies now dominate: in 2014, just six health insurance companies controlled 83% of the market (Yarrow). This concentration has dramatically increased prescription drug prices, premiums, and other out-of-pocket costs: the U.S. spent $200 more per person on prescription drugs than the trailing country in 2015 (Yarrow). As these costs increase, employers pass on a larger share to workers, who have lost bargaining power due to the decline of unionization and growth of both contracted and part-time labor (which typically do not include benefits) (Krueger). These trends have resulted in the decline of employer-provided health insurance since the 1990s (Reich 2/29).

Prior to the Affordable Care Act (ACA) of 2010, many low-income, non-disabled, and non-pregnant adults without dependent children were largely excluded from coverage due to Medicaid's extremely low income cap. The ACA expanded Medicaid to many of these individuals by mandating that states allow nearly all people with incomes below 138% of the Federal Poverty Line (FPL) to receive coverage; it also promised the federal government would pay 100% of states' additional Medicaid costs for 3 years, and gradually decrease this to 90% thereafter. In 2012, however, the Supreme Court ruled mandated expansion is unconstitutional and states are not required to expand eligibility, and thus 14 states have opted not to ("A Guide").

The federal government should intervene not only to connect vulnerable Americans to deserved and much-needed healthcare, but also to save money. Expanding access to Medicaid decreases the burden on largely state-funded social programs, producing budget savings in many states (Cross-Call). Medicaid services also enable many enrollees to find and maintain jobs, which stimulates the economy; expanding eligibility will thus ultimately prove both morally and economically advantageous (Mahan). The objective of the following policies will be to increase the amount of Americans eligible for Medicaid and improve their access to affordable healthcare.

Status Quo and Alternatives

Under the status quo, many states deny Medicaid eligibility to Americans who lack full-time jobs, dependent children, or a qualifying disability. Policy Alternative 1 would incentivize Medicaid expansion by offering every state federal funding for a new program specific to its needs; the policy requires states that have not expanded coverage to pay a higher state matching rate for these federal funds than expansion states. Policy Alternative 2 would penalize non-expansion by requiring states to decide between Medicaid expansion or a 1% reduction in their federal matching rate for Medicaid.

Criteria

1. *Effectiveness:* How effective the policy will be at expanding Medicaid eligibility to more low-income individuals. Given its significance to our goal, it is weighted on a 10 point scale.
2. *Political feasibility:* How much political opposition the policy will face in Congress from both expansion states and non-expansion states. It will be weighted on a 5 point scale.
3. *Administrative feasibility*: How difficult the organization and implementation of the policy's programs will be. It will be weighted on a 5 point scale.

Analysis

Effectiveness of Status Quo: At present, 14 states have not adopted the Medicaid expansion, and among these states the median eligibility limit for parents is just 40% of the FPL. This has left 2.5 million Americans in a "coverage gap," in which they earn too much to qualify for Medicaid but not enough to qualify for Marketplace subsidies, which become available at 100% of the FPL ("Where"). More than 9/10ths of these uninsured, low-income individuals reside in the South — ⅓ alone reside in Texas, and ⅕ in Florida. All Americans in the coverage gap would be eligible for Medicaid if their state had opted to expand (Garfield). These individuals within the coverage gap disproportionately experience chronic health conditions such as obesity, diabetes, and cardiovascular disease, but cannot receive adequate treatment without health insurance (Reich 4/19). Given these realities, the status quo earns a 1/10 for effectiveness.

Effectiveness of Alternative 1: Under this policy, all states that opt-in would receive federal funding for a new program that complements Medicaid and is targeted to their most urgent healthcare needs. The policy would require non-expansion states to pay for their new program at the rate they pay for Medicaid services, while expansion states would pay a lower rate equivalent to their CHIP contribution (Lambrew). If the proposed program attracts widespread public support within non-expansion states, voters will demand that their state opt into the program, which becomes much more cost-effective with Medicaid expansion. To further ensure that expansion is fiscally favorable for states, the federal government would extend the ACA offer to pay states' expansion costs ("A Guide"). Further, in preserving all current federal healthcare funding, this policy would encourage expansion states to retain expanded eligibility. However, the policy's opponents may argue that rather than incentivizing

poor states to expand Medicaid, the policy will appear as yet another financial burden; additionally, many states that resist expansion on political grounds may opt out of the program even if it saves them substantial money. <u>Considering these valid counterarguments, Alternative 1 earns an 7/10 for effectiveness.</u>

Effectiveness of Alternative 2: This policy would incentivize states to expand eligibility by imposing a modest penalty on those that refuse. Like Alternative 1, it would offer to fund nearly all of states' expansion costs, thus making it far more economical for states to opt into expansion. However, the penalty would only equate to 1% of the state's federal matching rate, so it may not be substantial enough to convince many non-expansion states, especially those that are morally opposed, to expand eligibility. Even more concerning, the policy could potentially backfire if penalized states decide to spend less on their low-income Medicaid recipients due to the decreases in federal funding. <u>For these reasons, Alternative 2 earns a 4/10 for effectiveness.</u>

Political feasibility of Status Quo: <u>The status quo scores a 5/5 for political feasibility.</u>

Political feasibility of Alternative 1: This policy is relatively feasible because it would not impose penalties on states for opting out of the new program. It would also balance out the distribution of state spending by allowing expansion states that are currently paying slightly more for Medicaid to pay less for their new program. However, poorer non-expansion states may argue that the new programs simply reward wealthier states by offering them more funding (Garfield). State representatives may also protest the federal government's selection of the targeted program, contending that they know their state's issues better than do federal legislators. Finally, federal representatives may argue that the policy, when combined with newly-expanded states' additional Medicaid expenses, will be too costly, as the new programs it establishes must be robust enough to make Medicaid expansion sufficiently attractive to non-

expansion states (Lambrew). Given these potential challenges, Alternative 1 earns a 3/5 for political feasibility.

Political feasibility of Alternative 2: Alternative 2 would face little resistance from expansion states, as the policy would have no effect on them, but it would likely face hostility from non-expansion states. The new penalty instigated by the policy would be relatively small in order to avoid the allegation used by the Supreme Court's 2012 ruling that the ACA's punishment for non-expansion is "economic dragooning" ("A Guide"). Even so, non-expansion states may argue that the penalty is unduly coercive and burdens their low-income residents the most. Another source of resistance could arise from wealthier non-expansion states who protest the penalty of 1% of federal matching funds, as it means the penalty will be larger for their states. Considering these likely objections, Alternative 2 scores a 2/5 for political feasibility.

Administrative feasibility of Status Quo: The status quo scores a 5/5 for admin. feasibility.

Administrative feasibility of Alternative 1: Because Alternative 1 necessitates creating new state-specific funding programs, implementation would be difficult. Federal officials must decide how much funding each new state program will receive based on factors such as population size and states' budgets. They must also determine what programs will be most effective based on each state's specific needs; for example, they could offer opioid addiction treatment programs in states with the highest addiction rates, such as West Virginia and Ohio (Lambrew). However, in states with large and diverse populations, such as California and New York, these decisions will demand more extensive research and deliberation. Given this rigorous but necessary planning, Alternative 1 earns a 3/5 for administrative feasibility.

Administrative feasibility of Alternative 2: This policy will be easier to implement, as it simply entails a 1% decrease in non-expansion states' federal matching rate for Medicaid. These rates are dictated by the Federal Medical Assistance Percentage (FMAP), which vary by state depending on per capita income and other factors ("Federal"). One potential difficulty, however, is that federal law established a minimum FMAP of 50%, and many states' FMAP is currently set at this rate; thus, reducing these states' FMAP would require amending the law to lower the minimum ("Federal"). For this reason, Alternative 2 earns a 4/5 for administrative feasibility.

Recommendation

Policy	**Effectiveness (10)**	**Political feasibility (5)**	**Administrative feasibility (5)**	**Overall Score (20)**
Status Quo	1/10	5/5	5/5	11/20
Alternative 1	7/10	3/5	3/5	13/20
Alternative 2	4/10	2/5	4/5	10/20

Under the status quo, non-expansion states will likely retain their eligibility restrictions and continue to curb many individuals' access to Medicaid; under Alternative 2, states may retaliate and pass on an even heavier burden to their low-income residents. As indicated by the above scores, Alternative 1 will most effectively close the Medicaid gap and increase healthcare access by incentivizing non-expansion states to expand Medicaid eligibility to more Americans. For these reasons, **I urge you to advocate for Alternative 1 for the welfare of our nation**.

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