The Universality of Medicaid at Fifty

Nicole Huberfeld*

INTRODUCTION

Fragmentation has aptly described the United States' historically decentralized, disjointed, and disintegrated approach to health care.[1] While fragmentation has endured in multiple dimensions—political, economic, organizational, relational, regulatory, and philosophical, to name a few—the exclusionary characteristic of American health care facilitated by fragmentation has been one of the greatest hurdles to access to needed care. Private health care providers have defended their prerogative to treat whomever, whenever, and the law largely has protected them from systemic integration[2] in either care or finance that could facilitate more "unified decision making."[3] Moreover, the United States has lacked a unifying theory of access to health care, existing in an ordered chaos sustained by a century-long political rejection of collective response to the human

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* H. Wendell Cherry Professor of Law and Bioethics Associate, University of Kentucky College of Law. Thanks to the participants in the Law of Medicare and Medicaid at 50 Symposium and to Jessica Roberts for helpful insights. Comments are welcome: nicole.huberfeld@uky.edu. Thanks always DT and SRHT.

1. *See generally* THE FRAGMENTATION OF U.S. HEALTH CARE (Einer Elhauge ed., 2010) (essays examining the "fragmented" healthcare system and prescribing institutional changes to eliminate fragmentation).

2. *See* Einer Elhauge, *Why We Should Care about Health Care Fragmentation and How to Fix It*, *in* THE FRAGMENTATION OF U.S. HEALTH CARE 1, 1-6 (Einer Elhauge ed., 2010) (discussing various dimensions of fragmentation). Applying economic theory of "firms and team production," Professor Elhauge discusses the deeply entrenched institutional problems of fragmentation:

> [H]ealth care raises the mother of all team production problems where input contributions are difficult to measure. . . . [I]n health care, shirking is likely to consist of failing to coordinate with others involved in the team effort on strategy, timing, and information-sharing in order to maximize health benefits per costs expended. . . . U.S. health care couples the mother of all team production problems with the mother of all refusals to use centralized ownership structures to solve them . . . .

Id. at 7. Both law and politics have protected health care providers from engaging in the integration commonly proposed during health care reform efforts that could facilitate a systemic approach. For example, Medicare's enabling statute began with assurance to physicians that the federal government will not interfere in the practice of medicine. 42 U.S.C. § 1395 (2012).

3. Elhauge, *supra* note 2, at 1 (defining fragmentation as "having multiple decision makers make a set of health care decisions that would be made better through unified decision making").

need for care through unitary health reform.[4]

The harmful effects of exclusion have been well studied and documented, but exclusion has remained an entrenched feature of American health care.[5] As a result, individuals have always been excluded from health care based on various measures unrelated to their actual need for medical care, such as ability to pay, employment, parental status, or race.[6] Even those covered by the nation's medical safety net—Medicaid—could only enroll if they were deemed "deserving" of governmental assistance. However, in 2010, the Patient Protection and Affordable Care Act (ACA) created universal access to health insurance, facilitated through a federal takeover of health insurance law.[7] The ACA shifted the law away from state-based private law to federally-based public law, shunned exclusion, and began to embrace a concept of health care as a public good, one that is inclusive and leveling. This shift started occurring incrementally through various federal laws over the years, but prior legislation rendered relatively small changes, and none universalized access to health care or health insurance until the ACA was enacted. In short, Congress legislated a new approach to health care through the ACA: universality.[8]

The ACA's statutory design of universal access to health insurance was a

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4. For a discussion of historic health care reform successes and failures leading to the Patient Protection and Affordable Care Act, see PAUL STARR, REMEDY AND REACTION pt. I-II (2011) [hereinafter STARR, REMEDY].

5. Andew P. Wilper et al., *Health Insurance and Mortality in U.S. Adults*, 99 AM. J. OF PUB. HEALTH 2289, 2291-94 (2009) (finding that over 45,000 people die each year due to access issues resulting from uninsurance). *See generally* INST. OF MED., CARE WITHOUT COVERAGE: TOO LITTLE TOO LATE (2002) (documenting how lack of insurance coverage creates barriers to access to health care that have measurably detrimental effects on health).

6. Even Medicare, the politically popular social insurance program for the elderly, is rooted in the individual's prior employment status. Americans must work in jobs that pay into the social security system for forty quarters to qualify for Medicare at age sixty-five, or they may pay premiums to access Medicare Part A (which typically does not require premiums). Because Medicare has permitted buy-in for people legally present in the United States, it is significantly less exclusionary than Medicaid; the point here is simply that work status has been a determinant of health care access in the United States. *See* 42 U.S.C. § 1395c (2012).

7. Not truly universal, as not every person within United States borders is eligible for health insurance. The largest excluded population is undocumented immigrants, who are excluded from Medicare, Medicaid, and exchanges through which insurance can be purchased. *See, e.g.*, Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1323(f)(3), 124 Stat. 119, 184 (2010) (excluding unlawful residents from access to insurance through exchanges). Medicaid covers emergency services that hospitals provide to undocumented immigrants, but they cannot enroll in Medicaid by receiving such services, unless the state in which the patient seeks care has opted to cover pregnant women and children who are undocumented. 42 U.S.C. § 1396b(v) (2012).

8. *See generally* Nicole Huberfeld & Jessica L. Roberts, *Medicaid Expansion as Completion of the Great Society*, 2014 U. ILL. L. REV. SLIP OPINIONS 1 (2014) [hereinafter Huberfeld & Roberts, *Great Society*], http://www.illinoislawreview.org/wp-content/uploads/2014/10/Huberfeld.pdf (analyzing universality as a civil right for Medicaid beneficiaries).

propitious step toward addressing the persistent exclusion facilitated by fragmentation in health care.[9] For example, private health insurance markets and practices have been rendered more uniform and inclusive by the ACA. But, the most important changes arguably have been effectuated in Medicaid, because it is no longer limited to certain categories of qualifying people or illnesses. The law of Medicaid is now inclusive rather than exclusive, because the ACA as written rendered all people earning up to 133% of the federal poverty level (FPL) eligible to enroll. This relatively simple statutory modification was a metamorphosis for the program that enrolled only the "deserving poor" for its first forty-nine years.[10]

This essay explores how the law of Medicaid at fifty creates a meaningful principle of universalism by shifting from fragmentation and exclusivity to universality and inclusivity. The universality principle provides a new trajectory for all of American health care, one that is not based on individual qualities that are unrelated to medical care but rather grounded in non-judgmental principles of unification and equalization (if not outright solidarity). To that end, this Essay first will study the legislative reformation that led to universality and its quantifiable effects. The Essay then will assess and evaluate Medicaid's new universality across four dimensions, namely governance, administration, equity, and eligibility. Each reveals a facet of universality that underscores this new principle's importance for health care into the future.

I. FROM FRAGMENTATION TO UNIVERSALITY

The United States has sustained a fragmented health care system that has excluded many people from both health insurance and health care. When other countries adopted social insurance or socialized medicine under the philosophy of solidarity after World War II, Americans rejected it, instead opting to continue the employer-provided private insurance apparatus encouraged by federal tax

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9. The ACA built on the existing structure of hybrid public/private insurance to achieve universal coverage. The majority of Americans will access insurance through their employers, by virtue of a penalty placed on large employers who do not offer affordable health insurance benefits, or through purchasing private insurance on health insurance exchanges with premium assistance for people earning 100% to 400% of the federal poverty level (FPL). The elderly and permanently disabled are still covered by Medicare. The poor are covered by Medicaid; and, as this essay discusses, Medicaid will cover all of the poor earning up to 138% of the FPL for the first time in Medicaid's history. Thus, the ACA maintains fragmented insurance coverage through large, small, and individual markets as well as through private and public plans, but it also unifies insurance customs through federal rules that make all Americans insurable and that prohibit insurance practices that made some people uninsurable through, for example, preexisting condition exclusions and other discriminatory practices. For a deeper explanation of the ACA's architecture, see STARR, REMEDY, *supra* note 4, at 239-46.

10. *See* Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 444-53 (2011).

benefits.[11] The employment-based private health insurance design excluded a large proportion of Americans, namely those who were elderly, poor, or otherwise outside worker-focused health insurance mechanisms. Historically, the elderly and poor were assisted by state-based medical welfare programs, but by the 1950's, states could not cover everyone who could not afford health care for lack of insurance. It was no secret that the elderly and the poor were bankrupted by their encounters with medicine, and state safety nets often failed for lack of funds, political support, and budgetary shortfalls.

When Congress enacted Medicaid, it aided some of those individuals who were excluded from health insurance by virtue of their poverty, but Medicaid's coverage was far from universal. Medicaid was a program for those outside of the private care, private insurance realm, and despite being part of the Great Society's push for legislative civil rights, Medicaid eligibility depended on the dual characteristics of being both poor and within states' historic, welfare-related definition of "deserving."[12] For the first forty-nine years of its existence, Medicaid never covered more than half of the poor because the program only protected low income Americans who were also pregnant women, children, blind, disabled, elderly, or deemed medically indigent.[13] Due to the ACA, however, Medicaid has become available to anyone who financially qualifies,[14] which had been proposed but was never passed.[15] This Part documents the move from fragmentation to universality, grounding its analysis in the universal coverage Medicaid now provides.

A. Medicaid's Statutory Transformation

Medicaid was created at the same time as Medicare, but the political capital was invested in creating social insurance for the elderly, who successfully lobbied for a national, universal health insurance program in Medicare.[16] The safety net for

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11. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 235-89 (1982) [hereinafter STARR, TRANSFORMATION].

12. ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA 46-47 (1974).

13. *See, e.g.*, David Orentlicher, *Rights to Healthcare in the United States: Inherently Unstable*, 38 AM. J.L. & MED. 326, 332 (2012) (discussing Medicaid's coverage limitations).

14. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001(a), 124 Stat. 119, 271-75 (2010). The companion legislation, the Health Care and Education Reconciliation Act (HCERA) of 2010, added a 5% income disregard, effectively raising new Medicaid eligibility to 138% of the FPL. *See* Health Care and Education Reconciliation Act (HCERA) of 2010, Pub. L. No. 111-152, § 1004(e), 124 Stat. 1029, 1036.

15. STARR, REMEDY, *supra* note 4, at 105, 175 (describing prior plans to expand Medicaid to deal with the uniquely American problem of the uninsured).

16. STEVENS & STEVENS, *supra* note 12, at 53.

the remainder of the poor was an afterthought.[17] By many accounts, no one expected Medicaid to last very long in its dual governmental, exclusionary structure.[18] Medicaid was a continuation of the Kerr-Mills program, which provided federal funding to the states to continue their medical assistance to the poor.[19] The Medicaid Act created a stronger federal framework, and Congress intended to ensure that states provided minimal economic security to the needy who qualified. But, even with strengthened federal rules, many decisions were left in the hands of the states, continuing fragmentation through patient exclusion and disunified administration that existed in health care long before Medicaid was enacted.[20]

While Medicaid offered generous federal funding to states and created a federal regulatory superstructure that states had to accept to receive funding, decisions about eligibility and provision of medical care echoed states' preexisting medical welfare programs. This meant that the stigmatizing concept of the "deserving poor" was carried forward into Medicaid, so only a limited portion of the poor would be eligible to enroll.[21] Also, limiting Medicaid to the deserving poor meant that "able bodied" adults were not eligible unless a state opted to spend its own funds on them, with no federal match. Medicaid's safety net clearly was not intended to catch everyone. Further, due to categorization of the poor to qualify for Medicaid, beneficiaries were marked as poor and either deserving or undeserving, isolating them from the rest of the population who received health coverage through private mechanisms.[22] Even though Medicaid was supposed to funnel the neediest into mainstream medicine, in many ways it sustained fractured medical care by virtue of its welfare-related stigma and such signifiers of lower status as the minimal reimbursement rates states paid to participating providers.[23]

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17. *See generally* Huberfeld, *supra* note 10, at 444 (detailing Medicaid's path dependence).

18. Rosemary Stevens & Robert Stevens, *Medicaid: Anatomy of a Dilemma*, 35 LAW & CONTEMP. PROBS. 348, 420 (1970) (predicting that Medicaid would be quickly "phased out").

19. *See* STEVENS & STEVENS, *supra* note 12, at 51.

20. Before Medicaid, states provided medical welfare to indigent patients who fit within the deserving poor categories. The states could not afford to provide medical welfare when the Great Depression hit, and from the passage of the first Social Security Act through 1965, the federal government provided more money and more rules to the states to support medical welfare programs. Each state had its own rules regarding medical welfare, though the provision of benefits to only the deserving poor was remarkably consistent. *See* Huberfeld, *supra* note 10, at 436-44 (discussing medical welfare programs that predated Medicaid).

21. Huberfeld, *supra* note 10, at 439-40 (illuminating the deserving poor standard).

22. DAVID G. SMITH & JUDITH D. MOORE, MEDICAID POLITICS AND POLICY 29-30, 39 (2010).

23. *Id.* at 47. Before Medicaid, the uninsured had few choices for health care. Many availed themselves of the care available in emergency departments under Emergency Medical Treatment and Labor Act's (EMTALA) strictures. 42 U.S.C. § 1395dd (2012) (requiring all hospitals that accept Medicare and that have emergency departments to treat anyone who presents with an emergency condition). Because many hospitals were nonprofit and tax-exempt, some indigent uninsured

Those who could qualify for Medicaid found that they were treated as "others," and those who were not eligible often were not treated at all.

Over time, Congress expanded Medicaid eligibility[24] by requiring states to provide comprehensive medical coverage to children under age twenty-one;[25] to expand coverage of the aged, blind, and disabled;[26] to expand eligibility standards for pregnant women and for children;[27] and to financially support drug coverage for people enrolled in both Medicare and Medicaid after the Medicare drug benefit was enacted.[28] Due to many small expansions through the years, Medicaid now financed the most health care of any payor, public or private, in the health care sector.[29] Even so, Medicaid excluded childless, non-elderly, non-disabled adults from its funding for most of its existence.

In 2010, Congress enacted another eligibility increase through the ACA, which required states to count as eligible everyone under age sixty-five earning up to 133% of the FPL. Thus, the ACA abandoned long-standing exclusion of non-elderly childless adults by making any low-income citizen (or legal resident) eligible to enroll in Medicaid. The ACA eliminated Medicaid's qualifying categories for purposes of eligibility (though not for other administrative purposes),[30] rejecting old judgments regarding who is "deserving" of medical

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received charity care that was absorbed by hospitals or written off as bad debt by hospitals. *See generally* Lisa Kinney Helvin, *Caring for the Uninsured: Are Not-For-Profit Hospitals Doing Their Share?*, 8 YALE J. HEALTH POL'Y L. & ETHICS 421 (2008) (discussing failure of nonprofit hospitals to provide adequate charity care and the result of such failures). But, many uninsured Americans who would not have been classified as indigent attempted to pay their medical debts and filed for bankruptcy in so doing because hospitals charged full, non-negotiated prices to private pay patients. *See generally* Melissa B. Jacoby, Teresa A. Sullivan & Elizabeth Warren, *Rethinking the Debates over Healthcare Financing: Evidence from the Bankruptcy Courts*, 76 N.Y.U. L. REV. 375 (2001) (presenting the third part of an empirical study showing that medical costs were the primary source of individual bankruptcy).

24. Nicole Huberfeld, Elizabeth Weeks Leonard & Kevin Outterson, *Plunging into Endless Difficulties: Medicaid and Coercion in* National Federation of Independent Business v. Sebelius, 93 B.U. L. REV. 1 (2013) (discussing Medicaid expansions).

25. Social Security Act Amendments of 1967, Pub. L. No. 90-248, §§ 301-02, 81 Stat. 821, 921-29 (1967) (codified in various sections of 42 U.S.C.).

26. Social Security Act Amendments of 1972, Pub. L. No. 92-603, §§ 201, 301, 86 Stat. 1329, 1370-74, 1465-78 (1972) (codified as amended in various sections of 42 U.S.C.).

27. Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 302, 102 Stat. 683, 750-51 (1988) (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(l) (2012)).

28. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066.

29. *Medicaid Moving Forward,* KAISER FAM. FOUND., (2014) [hereinafter *Medicaid Moving Forward*], http://kaiserfamilyfoundation.files.wordpress.com/2014/06/7235-07-medicaid-moving-forward2.pdf.

30. Under the Social Security Amendments of 1965, the different categories of qualifying poor have varying qualifying levels of earnings as well as options states can exercise to cover more categorically poor at higher earning levels; for example, the median coverage level for pregnant

assistance and starting movement toward the policy of inclusion that is universality. The post-ACA Medicaid shed its Elizabethan trappings,[31] inviting all comers to find security in its coverage.

In *NFIB v. Sebelius*,[32] the Supreme Court effectively rendered the ACA's Medicaid expansion optional for states, but, paradoxically, neither the ACA's nor Medicaid's statutory language was struck down or modified. The Court's unusual administrative remedy for its conclusion that the expansion was unconstitutionally coercive slowed the process of Medicaid expansion, because the Secretary of the Department of Health and Human Services could not penalize states that choose not to expand eligibility. But, the law of the Medicaid expansion that created the principle of universality was untouched. Whether states immediately expand Medicaid to the newly eligible or not,[33] universality is a statutory policy change that will have multiple, potentially long-lasting effects.

One obvious and immediate effect is the increase in coverage that is the inevitable result of expanding eligibility, regardless of state choice to opt in or out of expansion. Medicaid was already a key program for certain populations, but the expansion will have the effect of spreading Medicaid patients across the health care sector. Because they are no longer labeled worthy or unworthy of medical assistance, Medicaid patients will not be limited to the obstetrics unit, long term care, or pediatricians' offices. The infiltration of Medicaid patients throughout the health care sector will facilitate integration for the Medicaid population. The next subsection studies the numbers behind Medicaid's universality for both historically covered populations and the newly eligible to understand the implications of eligibility expansion in the context of universality.

B. Universality in Medicaid by the Numbers

A significant proportion of Americans will enroll in Medicaid to access medically necessary health care at some point in any given year—as many as one in four when the Medicaid expansion is completed. But, even before 2014, Medicaid covered approximately 20% of Americans, and for pregnant women, children, and the elderly, Medicaid was already ubiquitous.[34] As of 2010, Medicaid

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women is 185% FPL, which combines the 133% FPL mandatory coverage level with state options to cover women at higher levels of income. *See* 42 U.S.C. § 1396a(a)(10) (2012).

31. *See* Huberfeld, *supra* note 10, at 439.

32. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

33. For a study of the federalism dimensions of Medicaid expansion, see Tom Baker, Abbe R. Gluck, Nicole Huberfeld & Theodore Ruger, *The New Health Care Federalism: An Empirical and Theoretical Assessment of How Federalism Has Changed in Health Care and Beyond* (forthcoming 2015), http://ssrn.com/abstract=2511003.

34. *See Medicaid: A Primer: Key Information on the Nation's Health Coverage Program for*

covered 48% of all births in the United States[35] and nearly two-thirds of all unintended pregnancies.[36] Non-pregnant and childless women have not qualified for Medicaid and many have been uninsured. With the Medicaid expansion, approximately 4.6 million women of reproductive age will become eligible for Medicaid, which will increase the percentage of births covered by Medicaid as well.[37] Medicaid also has covered more than half of all complex deliveries, though that number may decrease after expansion because women are likely to become healthier due to the preventive care they will receive as part of the newly eligible population.[38]

As of 2013, Medicaid and the Children's Health Insurance Program (CHIP), which are separately funded but often have unified operations, provided health care coverage to more than 37% of all children under eighteen.[39] Public coverage of children has been extensive and especially concentrated among the approximately 20% of children who live in families earning less than 100% of the FPL.[40] For example, 73% of children in families earning less than 100% of the FPL are covered by Medicaid/CHIP,[41] and 45% of children in families earning between

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Low-Income People, KAISER FAM. FOUND., 8, (2013) [hereinafter *Medicaid: A Primer*], http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf.

35. Anne Rosier Markus et al., *Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform*, WOMEN'S HEALTH ISSUES, Sept.-Oct. 2013, at e273–e280, http://www.whijournal.com/article/S1049-3867(13)00055-8/pdf. This rate is high in part because states have historically increased income eligibility levels for pregnant women and in part because poor women have less access to birth control and higher rates of unintended pregnancies. *See id.* at e274; *Medicaid: A Primer*, *supra* note 34, at 9.

36. Adam Sonfield et al., *The Public Costs of Births Resulting from Unintended Pregnancies: National and State-Level Estimates*, 43 PERSPS. ON SEXUAL & REPROD. HEALTH 94 (2011).

37. *Id.*

38. *Id.*

39. Robin Rudowitz, Samantha Artiga & Rachel Arguello, *Children's Health Coverage: Medicaid, CHIP and the ACA*, KAISER FAM. FOUND. (2014), http://kaiserfamilyfoundation.files.wordpress.com/2014/03/8570-children_s-health-coverage-medicaid-chip-and-the-aca1.pdf.

40. Carmen DeNavas-Walt & Bernadette D. Proctor, *Income and Poverty in the United States: 2013*, U.S. CENSUS BUREAU 14 (2014), https://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-249.pdf. Children are proportionally overrepresented in the low-income population: "Children represented 23.5 percent of the total population and 32.3 percent of people in poverty." *Id.*

41. Children who are eligible may not be enrolled if their parents are not also eligible; this is a different aspect of the welcome mat effect that the ACA would have because newly covered parents would have the knowledge and incentive to enroll both themselves and their already eligible children in Medicaid. *See, e.g.*, Genevieve M. Kenney et al., *A First Look at Children's Health Insurance Coverage under the ACA in 2014*, URBAN INST. 2 (2014), http://hrms.urban.org/briefs/Childrens-Health-Insurance-Coverage-under-the-ACA-in-2014.pdf; *see also* Nicole Huberfeld & Jessica Roberts, *An Empirical Perspective on Medicaid as Social Insurance*, 46 U. TOLEDO L. REV. [hereinafter Huberfeld & Roberts, *Empirical Perspective*] (forthcoming 2015),

100-250% of FPL are enrolled, but only 16% of children in households earning between 250-399% of FPL are Medicaid enrollees.[42] Medicaid will now cover more children aged five to eighteen, whom prior to the ACA were only covered up to 100% of the FPL. Estimates are that about 600,000 children enrolled due to the ACA in 2014,[43] and predictions indicate that millions more will be covered when hold out states opt in to Medicaid expansion given the concentration of uninsured children in the South.[44]

Many people over age sixty-five will require institutional long-term care,[45] which Medicare reimburses only when skilled nursing is required; consequently, Medicaid has been funding at least 40% of all long-term care costs in the United States.[46] That means Medicaid finances care for more than 60% of long-term nursing home residents, despite their Medicare coverage[47]; in some states, that number is higher.[48] Neither the ACA nor Medicaid expansion will change this coverage much, given that expansion is concentrated in people under sixty-five. Non-elderly people who become disabled are eligible for Medicaid, and they have been included in Medicaid's long-term care coverage for decades. While the ACA facilitated experimentation with community-based long-term care rather than institutionalized care, long-term care coverage was not radically reformed by the ACA.[49] As such, it contributes to Medicaid's universality going forward because it was already so important for the elderly and disabled populations.

Covering only the "deserving poor," Medicaid provided health care coverage to more than one in five Americans before the ACA,[50] and the Congressional

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http://ssrn.com/abstract=2532495.

42. RUDOWITZ et al., *supra* note 39.

43. *Recent Trends in Medicaid and CHIP Enrollment: Analysis of CMS Performance Measure Data through August 2014*, KAISER FAM. FOUND. 4 (2014), http://files.kff.org/attachment/recent-trends-in-medicaid-and-chip-enrollment-analysis-of-cms-performance-measure-data-issue-brief.

44. *See, e.g.*, Joan Alker et al., *Uninsured Children 2009-2011: Charting the Nation's Progress,* GEO. UNIV. HEALTH POL'Y INST. CTR. FOR CHILDREN AND FAMILIES 4-5 (2012), http://ccf.georgetown.edu/wp-content/uploads/2012/10/Uninsured-Children-2009-2011.pdf.

45. DONALD REDFOOT & WENDY FOX-GRAGE, AARP PUB. POL'Y INST., MEDICAID: A PROGRAM OF LAST RESORT FOR PEOPLE WHO NEED LONG-TERM SERVICES AND SUPPORTS 1 (2013) (stating that seven out of ten people turning sixty-five will need long-term care at some point in their lives).

46. *Medicaid: A Primer*, *supra* note 34, at 4.

47. *Id.*

48. *See* 155 CONG. REC. E2468, E2469-70 (daily ed. Oct. 8, 2009) (statement of Rep. Mike Rogers attaching letter by Gov. Charlie Crist, dated September 17, 2009) (describing Medicaid as financing long term care for both seniors and disabled people).

49. *Community-Based and Long-Term Services and Supports*, MEDICAID.GOV, http://www.medicaid.gov/affordablecareact/provisions/community-based-long-term-services-and-supports.html (last visited Nov. 1, 2014).

50. For deeper discussion of the demographics of Medicaid's enrollment, see Huberfeld & Roberts, *Great Society*, *supra* note 8; Huberfeld & Roberts, *Empirical Perspective*, *supra* note 41.

Budget Office estimates the number of new Medicaid enrollees at more than eighteen million by 2018 and another two million by 2024, which will increase Medicaid's enrollment to one in four Americans.[51] In addition to covering over half of all pregnancies, more than a third of all children, and well over half of all long-term nursing home residents, previously excluded low-income parents and childless adults who cannot obtain health insurance through employers will now be included in Medicaid's medical assistance.

Of the newly eligible adults, most are either the working poor or employees of small businesses, as uninsured adults generally fall into two categories: workers who are self-employed or work for small companies that cannot offer insurance benefits, or those in low wage jobs that do not offer insurance or that do not offer affordable insurance. Among newly eligible Medicaid beneficiaries, 79% have at least one worker in the family, with 63% in full time employment and 16% in part time employment.[52] Many of the newly eligible are workers who want health insurance but are not offered it or cannot afford it, and Medicaid now acts as the employment benefit of health insurance that wealthier workers have enjoyed since the 1940s.

In short, Medicaid covers more lives than any other health insurance mechanism in the United States, and it has surpassed Medicare in enrollment and total spending.[53] The statutory philosophy behind that increase was a federal policy choice to include all Americans in health insurance coverage so that they are no longer excluded based on individual characteristics or subject to the physical and economic insecurity of inconsistent health care access.[54] The universality encompassed by this policy choice is broader in some respects than social insurance because it is not grounded in work status (in contrast to Medicare, large group, and small group insurance). Medicaid is now a de facto form of social insurance in our health care system given that it is covering a substantial portion of the working poor. But, it also covers those who cannot work, cannot find work, or are unable to work, and it provides more thorough grounding in access to health

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51. *The Budget and Economic Outlook: 2014 to 2024*, CONG. BUDGET OFF 58 (2014), http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-Outlook2014_Feb.pdf ("By 2024, about 89 million people will be enrolled in Medicaid at some time during the year.").

52. *Key Facts About the Uninsured Population* KAISER FAM. FOUND. 2, 4, (2013), http://kaiserfamilyfoundation.files.wordpress.com/2013/09/8488-key-facts-about-the-uninsured-population.pdf.

53. *Medicaid Moving Forward*, *supra* note 29, at 1.

54. President Barack Obama, On Behalf of My Mother, Remarks at the Signing of Patient Protection and Affordable Care Act (Mar. 23, 2010), http://www.whitehouse.gov/blog/2010/03/23/behalf-my-mother ("And we have now just enshrined, as soon as I sign this bill, the core principle that everybody should have some basic security when it comes to their health care.").

care than insurance coverage that is linked to worker status. It is less fragmentary and more equalizing than employment-based insurance, which makes it an important source of economic and social stabilization for low income workers. The principle of universality has bypassed the resistance to solidarity that stymied health care reform for many years, and instead of being "phased out," Medicaid has embodied this new legislative principle.[55]

II. UNIVERSALITY IN FOUR DIMENSIONS

Medicaid's expansion to capture individuals who historically have fallen into gaps enlarged by fragmentation demonstrates a move from exclusivity to inclusivity in the American health care system. Yet, non-exclusion contains important ramifications beyond enrollment. This part explores four dimensions of universality—governance, administration, equity, and eligibility—that provide useful lenses through which to consider the multi-layered implications of universality.

A. Universality in Governance

Medicaid has long been considered a classic cooperative federalism program.[56] To the Supreme Court, this has meant that the federal government can drive policy with large sums of money, but it cannot force states to partner in Medicaid.[57] To the federal government, this has meant that Congress occasionally drives health care policy forward by expanding Medicaid eligibility or medical coverage, and then HHS negotiates with the states to enforce the reform. To the states, this has meant large transfers of federal funding that help to balance state budgets by covering indigent patients while states engage in diverging and largely uncontested interpretations of the Medicaid Act.

In addition to these inter-governmental dynamic negotiations, Medicaid has been partially privatized by waiver. The ACA ushered in negotiations with HHS to expand eligibility, rendered more aggressive on states' part by the holding in *NFIB v. Sebelius*. Each of the expansion-related waiver requests thus far contains a privatization element, whether by placing newly eligible enrollees in qualified health plans in the exchanges, or by funneling the newly eligible into Medicaid

55. *See* Stevens & Stevens, *supra* note 18, at 420.

56. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2629 (2012) (Ginsburg, J., concurring in part and dissenting in part); Harris v. McRae, 448 U.S. 297, 308 (1980).

57. *See, e.g.*,Sebelius, 132 S. Ct. at 2604-07 (Roberts, C.J., holding the Medicaid expansion as written in the ACA unconstitutionally coercive because the states could not choose whether to expand their categories of eligibility without losing all of their Medicaid funding).

managed care plans, or by seeking a health savings account format for them.[58] Medicaid has been a hybrid program, weaving together federal and state policy and administration, public and private systems, and the deserving poor with others in the health care system. HHS's authority to grant section 1115 waivers, which provide states with flexibility in Medicaid and other programs governed by the Social Security Act to create demonstration programs, always has included the ability to authorize privatization, but the federal/state, public/private hybrid has not been subject to the universality backstop until now. The multifaceted policy implementation in Medicaid could be deemed an example of new governance,[59] or it could be viewed as a facet of heath care fragmentation.

Over time, federal rules have increased in the Medicaid program, and the states often have pushed back against greater federal superstructure.[60] While this dynamic is a gripping study in modern federalism, experimentation often occurs for budgetary reasons and not for the benefit of Medicaid enrollees. States need federal funding to provide medical assistance, but they often reject or attempt to bypass the federal rules that come with copious funding for political reasons. Medicaid is the largest transfer of wealth from the federal government to the states in American history. But, the states remain part of Medicaid's administration for path dependent reasons—they have always been involved in welfare medicine, and so they remain involved in welfare medicine. This bifurcated governance is inefficient both administratively and economically and is exacerbated by states' slow path to expansion, which prolongs exclusionary policy in opt-out states.

HHS has been expending tremendous effort negotiating with states in the wake of *NFIB v. Sebelius* to convince them that they should expand Medicaid eligibility and to consider their various proposals for demonstration waivers.[61] If the program were fully federalized, as I have discussed elsewhere,[62] expansion would be complete by now. HHS administrators could instead spend time on administering the program rather than negotiating with reticent, self-serving states

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58. *See* Baker et al., *supra* note 33.

59. *See* THE TOOLS OF GOVERNMENT: A GUIDE TO THE NEW GOVERNANCE 15 (Lester M. Salomon ed., 2002) (offering a way station between "command and control" governance and pure privatization through a negotiated management format).

60. For example, the National Governors Association has a standing policy statement regarding health care that demands both "proper[]" federal funding and safeguarded state "flexibility." National Governors Association, NGA Policy Position HHS-05 Health (2013), http://www.nga.org/cms/home/federal-relations/nga-policy-positions/page-hhs-policies/col2-content/main-content-list/health.html (adopted at NGA's Winter 2013 meeting).

61. *See, e.g.*, Nathaniel Weixel, *Burwell Urges Hesitant Governors to Work with HHS on Medicaid Expansion*, BLOOMBERG BNA HEALTH CARE DAILY REP., Nov. 4, 2014 (reporting on Secretary Burwell's remarks to the fall meeting of the National Association of Medicaid Directors that invited any state interested in Medicaid expansion to talk with her).

62. *See generally* Huberfeld, *supra* note 10.

who hold out for political purposes. Allowing states to maintain a co-governance role in Medicaid is not supported by finance or by medical standards.[63] Universality provides a developing legislative structure that informs HHS's management of Medicaid in its negotiations with states, and it can provide a new direction for Medicaid's governance by clarifying the national government's role in public health insurance, which is already substantial. The ongoing reliance on states in health care governance should be reconsidered in light of the principle of universality. While some states have accepted the new federal law of Medicaid as their guide for Medicaid enrollment, the continued role of states creates a tension with the goals of health care reform by slowing Medicaid expansion for political purposes. Governance viewed through the lens of universality supplies another reason that the experiment of the states is no longer appropriate in Medicaid.

B. Universality in Administration

The principle of universality provides a new path for battling administrative fragmentation in health care. Health care in the United States has been decentralized in decision-making, delivery, finance, information sharing, and other ways. Medicaid has been a particularly exaggerated form of fragmented administration, because each state creates its own structure for complying with the federal Medicaid Act. Although the Medicaid Act has provided a baseline for states regarding standards for medical welfare, the program has allowed huge amounts of state variation within the federal rules so long as states have not provided less (on paper) than the federal statute requires.[64]

While some aspects of Medicaid historically have been unwaivable—such as eligibility and enrollment for people who meet the terms of the Medicaid Act, statewide benefit consistency, and freedom of choice among health care providers participating in Medicaid—states have been able to designate for HHS how they will comply with the many aspects of the Medicaid program with little pushback so long as the state's plan was budget neutral.[65] States have often divided different categorically eligible enrollees into more or less deserving categories. For example, every state has chosen to increase the income level at which pregnant women will be covered. But, only some states have provided benefits to parents of

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63. *See id.* at 743-49.

64. *See generally* John Holahan, *Variation in Health Insurance Coverage and Medical Expenditures: How Much Is Too Much?*, *in* FEDERALISM & HEALTH POLICY (John Holahan, Alan Weil & Joshua M. Wiener, eds. 2003).

65. Ctrs. for Medicare and Medicaid Servs., *Section 1115 Waivers*, MEDICAID.GOV, http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html (last visited Dec. 1, 2014).

eligible children above the level dictated by the Medicaid Act.[66] These options and inconsistencies make for overly complex administration at both federal and state levels, as well as inequitable medical coverage for enrollees (discussed further below).

HHS cannot manage each state at a granular level.[67] Only when it is quite clear that a state is running afoul of the Medicaid Act does HHS confront a state regarding compliance. Further, HHS never pulls state funding, because its policy goals are different from a state's—HHS wants to ensure that bodies are in the program, getting covered for as much health care as possible, while states habitually are using federal funding to balance their budgets.[68] Each state makes some individualized decisions regarding the medical coverage of its Medicaid population, the payment rates for health care providers who participate in the Medicaid program, and the way that the state will contract with managed care entities that will cover the state population. These decisions, to which HHS generally defers, have created a fifty state patchwork of Medicaid benefits, eligibility, and rules that renders the Medicaid program quite fragmented, especially if an enrollee ever changes residency.

This highly decentralized approach to Medicaid makes health care for low-income citizens administratively inefficient.[69] This aspect of fragmentation creates wildly varying standards of health care access and care that impact patient care. For example, the Office of the Inspector General (OIG) recently issued an evaluation entitled State Standards for Access to Care in Medicaid Managed Care, in which the OIG appraised each state's Medicaid managed care contracting and found state oversight of quality control and access to care lacking.[70] Not only did many states fail to set standards for access to care, but also the OIG stressed that HHS must "strengthen oversight" of the program to ensure protection of enrollees

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66. *Medicaid Income Eligibility Limits for Adults at Application, as of August 28, 2014*, KAISER FAM. FOUND.(2014), http://kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-adults-at-application-2014 (last visited Nov. 1, 2014).

67. *See generally* Brief of Former HHS Officials as Amici Curiae in Support of Respondents, Douglas v. Indep. Living Ctr. of S. Cal., Inc., 132 S. Ct. 1204 (2012), (Nos. 09-958, 09-1158, 10-283), 2011 WL 3706105.

68. *See, e.g.*, Teresa A. Coughlin & Stephen Zuckerman, STATES' USE OF MEDICAID MAXIMIZATION STRATEGIES TO TAP FEDERAL REVENUES: PROGRAM IMPLICATIONS AND CONSEQUENCES, URBAN INST. (2002), http://www.urban.org/uploadedPDF/310525_DP0209.pdf.

69. *See* Randall R. Bovberg et al., *State and Federal Roles in Health Care: Rationales for Allocating Responsibilities*, *in* FEDERALISM & HEALTH POLICY 25, 44 (John Holahan, Alan Weil & Joshua Wiener, eds. 2003); Marilyn Moon, *Making Medicaid a National Program: Medicare as a Model*, *in* FEDERALISM & HEALTH POLICY 325, 330 (John Holahan, Alan Weil & Joshua Wiener eds., 2003).

70. Suzanne Murrin, *State Standards for Access to Care in Medicaid Managed Care*, DEP'T HEALTH & HUMAN SERVS. (2014), http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf.

when state administration fails.[71]

The theory of universality can simplify Medicaid's administrative morass. Although HHS has conciliated states in the interest of policy entrenchment and increased health care access through maximizing the lives covered, HHS now must exercise greater control in the administrative choices and procedures in Medicaid. HHS is responsible for directing and monitoring states' compliance with universalism. Though *NFIB v. Sebelius* limited HHS's authority to enforce state participation in Medicaid's expansion, once a state does signal interest in eligibility expansion, HHS has a stronger hand to play. State proposals that could diminish the inclusivity of Medicaid expansion should not be entertained, and HHS could do much to centralize the multitudinous state decisions to ensure the basic care for Medicaid beneficiaries is not full of gaps.

While universality does not speak directly to these internal administrative issues, and the *NFIB* spin on universality has complicated Medicaid administration temporarily because of the subsequent executive branch invitation to negotiate through waiver proposals, ultimately, universality will furnish a backstop to state requests for flexibility through welfare-like "experiments" with requirements that are unrelated to health care. Proposals such as work-search requirements are not only outdated in light of the principle of universality, but they also increase the need for administrative oversight and further diversify it by virtue of the tailoring required of such requests. Other requirements, such as wellness programs or co-payments enforceable for portions of the newly eligible population, also can increase administrative complications due to increased diversification of state Medicaid programs, which are harder for the limited HHS staff to manage.[72]

HHS must enable enrollment in Medicaid in order to entrench the new federal policy of universality, but it cannot do so at the expense of enrollees' health status, which is jeopardized when states take a laissez faire approach to Medicaid administration. Now that universality has detached Medicaid from old stigmatizing, disequalizing, welfare-like conditions, the states should not be permitted to negotiate new welfare conditions into the expansion, which only complicate administration of the program. While the negotiations between HHS and the states display a blazingly dynamic federalism, which is both vertical and horizontal, that federalism is not necessarily of value to enrollees, especially without assurance that HHS will provide real oversight as states negotiate, respond, and react.[73]

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71. *Id.* at 17-20 (instructing the Centers for Medicare and Medicaid Services, a sub-agency of HHS, to increase oversight of state managed care programs).

72. *See generally Premiums and Cost-Sharing in Medicaid*, KAISER FAM. FOUND. (2013), http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8416.pdf.

73. *See* Baker et al., *supra* note 33.

C. Universality in Equity

Upon enactment in 1965, one clear goal for Medicaid was to mainstream eligible beneficiaries into the medical care available to everyone else. Over the past fifty years, America's fragmented health care system has facilitated continued segregation for people of means in private insurance and people who are low income, whether uninsured or in Medicaid.[74] It is widely understood that the uninsured do not have consistent access to health care and that they delay care or do not receive needed care due to cost.[75] Thus, the greatest health care inequity currently exists for low income populations in states that have not yet expanded their Medicaid eligibility standards. Until those states expand, Medicaid's inclusivity is thwarted, and people will not receive medically necessary care due to lack of insurance coverage. The holdout states correlate strongly to the states that have high Medicaid federal matching rates and high levels of uninsurance, raising questions about the political theater being staged in the opt out states.

Yet, once enrolled in Medicaid, enrollees still can experience difficulty finding health care providers who will accept them as new patients.[76] This inequity in access and care could increase instability as expansion progresses over the next several years. Some doctors are unable or unwilling to treat Medicaid patients, and Medicaid beneficiaries sometimes face obstacles in finding basic preventive services.[77] While this may result in part from Medicaid patients residing in medically underserved areas, Medicaid patients in health care rich environments reportedly experience some under-service as well.[78]

The ACA attempted to address inequitable access by increasing Medicaid's primary care physician payments to Medicare levels for 2013 and 2014, and some evidence indicates that the increased payments drew physicians into Medicaid who

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74. *See, e.g.*, INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE (Brian D. Smedley et al. eds., 2003).

75. *See, e.g.*, *Health Insurance and Access to Care*, CTRS. FOR DISEASE CONTROL & PREVENTION (2012), http://www.cdc.gov/nchs/data/factsheets/factsheet_hiac.pdf; COMM. ON HEALTH INSURANCE & ITS CONSEQUENCES, INST. OF MED., AMERICA'S UNINSURED CRISIS: CONSEQUENCES FOR HEALTH AND HEALTH CARE (2009).

76. The Office of the Inspector General's (OIG) report on state oversight of managed care for Medicaid populations discussed this problem to a degree. *See* STATE STANDARDS FOR ACCESS TO CARE IN MEDICAID MANAGED CARE, *supra* note 70, at 8-14 (discussing findings that states do not ensure adequate access to physicians); *see also* Robert Pear, *For Medicaid Enrollees, Access to Care Is Hard to Find*, N.Y. TIMES, Sept. 28, 2014, at A26 (discussing the OIG report).

77. *See, e.g.*, 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, 1184-86 (2013) (discussing various physicians' willingness to accept new Medicaid patients).

78. *See, e.g.*, Leighton Ku et al., *The States' Next Challenge—Securing Primary Care for Expanded Medicaid Populations*, 364 NEW ENG. J. OF MED. 493 (2011).

would not ordinarily have participated.[79] But, without congressional action or voluntary state continuation, this reimbursement increase will diminish in 2015 and may leave new enrollees with renewed inequities.[80] It is possible that Medicaid enrollees purchasing insurance from qualified health plans through premium assistance in the exchanges in waiver states may face less discrimination accessing care, in which case those demonstration waivers will have served a more important purpose than the political negotiation and strategizing discussed above. But it is too soon to know if the cloak of private insurance coverage is enough to facilitate equal access for Medicaid beneficiaries.

An additional source of inequity is Medicaid providers' and enrollees' tenuous ability to enforce the Medicaid Act against noncompliant states in federal court. The Supreme Court will hear again the question of whether private parties can enforce the Medicaid Act by Supremacy Clause actions this term, and the prospects are dim for continued viability of private actions.[81] Just two terms ago, the Court barely upheld such private actions in *Douglas v. Independent Living Center* by allowing HHS to exercise primary jurisdiction and bypassing the Supremacy Clause question in deference to the agency's interpretation of the statutory question of adequate reimbursement in that case.[82] Losing the ability to enforce the terms of the Medicaid Act through private rights of action would decrease HHS oversight, as the agency has stated publically that it relies on private actions to alert it to state mistreatment of the Medicaid program and its providers and beneficiaries. Without on the ground, de facto private enforcers, HHS would have a much harder job ensuring that the newly universal program achieves equitable care for its new and old populations. In recognition of this potential regulatory failure, Congress incorporated new reporting requirements through the ACA into the Medicaid Act that require states to report on equal access to care for Medicaid beneficiaries.[83] But, HHS has not clearly indicated how it will use state reports to increase equal access to care for Medicaid beneficiaries.

The universality principle should ensure adequate and equal access to care,

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79. Adam S. Wilk, *Differential Responses Among Primary Care Physicians to Varying Medicaid Fees*, 50 INQUIRY 296 (2013) (studying evidence of physician uptake due to the increase in payments).

80. *The ACA Primary Care Increase: State Plans for SFY 2015*, KAISER FAM. FOUND. (Oct. 28, 2014), http://kff.org/medicaid/perspective/the-aca-primary-care-increase-state-plans-for-sfy-2015.

81. Exceptional Child Ctr. v. Armstrong, 567 Fed. App'x 496 (9th Cir. 2014), *cert. granted*, 83 U.S.L.W. 3077 (U.S. Oct. 2, 2014) (No. 14-15).

82. 132 S. Ct. 1204 (2012); *see also* Nicole Huberfeld, *Where There Is a Right, There Must Be a Remedy (Even in Medicaid)*, 102 KY. L. J. 327 (2014); Nicole Huberfeld, *Post-Reform Medicaid Before the Court: Discordant Advocacy Reflects Conflicting Attitudes*, 21 ANNALS HEALTH L. 513 (2012).

83. Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26,342 (proposed May 6, 2011) (to be codified at 42 C.F.R. pt. 447).

but if states refrain from expanding their Medicaid programs for very long, then a different aspect of equity is also jeopardized. States could sustain the exclusionary practices in health care that the ACA is meant to end, thereby decreasing equity in health care access. Though all states will eventually expand (it took many years for all states to participate in the first iteration of Medicaid fifty years ago), until they do, health care equity will not be achieved. In addition to harming the health of low-income residents who would qualify for Medicaid in opt in states, state reticence to expand could affect private insurance plans. Enrollees often move in and out of Medicaid due to fluctuations in income, a phenomenon known as churn. Without Medicaid expansion, the newly eligible population in opt out states will be sicker when it moves into private insurance through exchanges or employers, raising costs for all.

D. Universality in Eligibility

Medicaid contains eight statutory categories of eligibility now, with the eighth being childless adults under the age of sixty-five earning up to 133% of the federal poverty level—the newly eligible population.[84] Medicaid eligibility should be integrated in light of universality. The categories of eligibility, which were proxies for policy determinations as to who was considered "deserving" of medical assistance, are no longer germane. Condensing eligibility into one level, uniform category would reinforce the philosophy of universality and would complement the other dimensions of governance, administration, and equity.

Under current law, state Medicaid agencies determine whether an applicant meets the particular standards for financial eligibility in a given state in light of their categorical status, a status that is now antiquated and unnecessarily complicated. Eligibility should be a straightforward financial criterion, with no discrimination among the poor depending on whether they are pregnant, disabled, elderly, childless, or something else.

Single category eligibility would require reconsideration of technical differences between existing categories. For example, the Medicaid Act requires very specific medical care for children, which should be retained in recognition of their unique vulnerability.[85] Another example is the optional coverage of pregnant women earning more than 133% of the FPL that most states provide (median coverage level was approximately 200% of the FPL as of June 2014).[86] Eligibility

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84. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012). The ACA also expanded coverage of poor children aged 5 to 18 up to 133% of the FPL from 100% of the FPL, but children were already covered, so this is not new eligibility, just expanded eligibility. *See id.*

85. 42 U.S.C. § 1396d(r) (2012).

86. *Where Are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults as of April 1, 2014*, KAISER FAM. FOUND. (2014),

unification should not occur at the expense of patients who have benefitted from state largess through optional Medicaid coverage. But, if the ACA's private insurance reforms succeed over time, then states will not need to cover certain populations above 133% of the FPL, because they will become privately insured through employers or be able to purchase individual or small group insurance on the health insurance exchanges.

Unified eligibility would be a logical conclusion to many aspects of the ACA's and Medicaid's new universality. For example, the "no wrong door" enrollment facilitated by the ACA, which allows uninsured people to enter into the health insurance system by submitting one application that will direct them to the type of insurance coverage that they may acquire given financial circumstance, would be greatly simplified and enhanced by a single category of eligibility for Medicaid.[87] Unified eligibility would be consistent with the new universality and inclusion embodied by the law of Medicaid.

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In sum, universality suffuses multiple dimensions of Medicaid, diminishing the program's fragmentation while also revealing a fragility in the ACA's expansion. HHS is engaged in a highly pragmatic set of negotiations with states that invites expansion in order to cover lives and entrench the new federal policy of inclusion. Contrariwise, the agency must develop its underused ability to do more than implore—it can and should enforce the ACA's statutory principle of universality and rejection of exclusion. HHS can strengthen Medicaid as it expands and settles into expansion over the coming years. But, if HHS does not, then fragmentation in Medicaid will continue, not only to the detriment of enrollees, but also to the detriment of the program's finances.[88] Though universality could appear costly in terms of increasing enrollment, it is also very likely to produce economic benefits through such effects as streamlining, long term benefits related to preventive care, and unified policy clarification.[89] Not only is universality the

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http://kaiserfamilyfoundation.files.wordpress.com/2014/06/7993-05-where-are-states-today-fact-sheet-june-2014.pdf.

87. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2201, 124 Stat. 119, 289-91 (2010).

88. States have long struggled to finance Medicaid, especially during economic recessions. *See, e.g.*, Moon, *supra* note 69, at 329.

89. *See* Sherry Glied & Stephanie Ma, *How States Stand to Gain or Lose Federal Funds by Opting In or Out of the Medicaid Expansion*, THE COMMONWEALTH FUND (2013), http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2013/Dec/1718_Glied_how_states_stand_gain_lose_Medicaid_expansion_ib_v2.pdf (quantifying and explaining why Medicaid expansion is an economic net gain for most if not all states); Robin Rudowitz et al., *Issue Brief: Implementing the ACA: Medicaid Spending & Enrollment Growth for FY 2014 and FY 2015*,

new law of Medicaid, but regardless of theoretical design, it is economically sensible too.

CONCLUSION

The elderly and the poor were once in the same bucket; undesirable as patients, often expensive or complex to treat, and often unable to afford their own care. The elderly were elevated to Medicare's social insurance, a program unique in America's historically limited redistributive policy, through effective lobbying that federalized and standardized their benefits. While the principle of inclusion was codified for the elderly in Medicare in 1965, it took almost another fifty years to codify the precept that non-elderly people also merit non-exclusionary coverage.[90] Medicaid's de facto social insurance is not as stable as Medicare's, though, because Medicare beneficiaries do not age out of their coverage and form a politically cohesive group. From an enrollment standpoint, the Medicaid population is less consistent than Medicare's. Further, Medicaid is a different kind of insurance because of the variation that state participation introduces into the program.

This essay has explored the shift from fragmentation and exclusion to universality and inclusion across four different spheres. While this shift is a positive normative development in health care, an obvious downside to Medicaid's new universality is that a person must be very low income to benefit from it. Another disadvantage of building universality on Medicaid is that it has not been a particularly stable program, often instead approximating a political hot potato. Nevertheless, expanding Medicaid has long been on the health reform radar, and the ACA took considerable steps toward both nationalizing and universalizing Medicaid. Medicaid's new universality will be felt not only by the sheer number of people in the program as it grows over the next several years, but also in the possible defragmenting effects it will have in the health care system as a whole.

HHS must recognize its key role in effectuating universality, which is now the law of Medicaid. Centralized guidance with universality as its focal point will help

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KAISER FAM. FOUND. (2014), http://files.kff.org/attachment/implementing-the-aca-medicaid-spending-issue-brief (Medicaid spending increases in opt out states in 2014-15 will be greater than in expansion states due to lack of federal funding); Reid Wilson, *Study: Refusing Medicaid Expansion Will Cost States Billions of Dollars*, WASH. POST (Dec. 6, 2013), http://www.washingtonpost.com/blogs/govbeat/wp/2013/12/06/study-refusing-medicaid-expansion-will-cost-states-billions-of-dollars (explaining that states spend more on attempting to draw new businesses to the state than they will spend on Medicaid expansion).

90. The original Medicaid Act contained a provision that admonished states to expand Medicaid to everyone who qualified financially by 1975, but the provision was postponed and then repealed. SMITH & MOORE, *supra* note 22, at 50.

this newly inclusive form of medical assistance accomplish the principal philosophical underpinning of the ACA, which initiates a shared responsibility for health care, if not fully recognizing health care as a public good. Medicaid's transition to universality is a story still in the writing—one that will potentially shape health care for more than a quarter of Americans for years to come.