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MEDICAID EXPANSION UNDER THE AFFORDABLE CARE ACT: A CASE FOR
MISSISSIPPI

by
Cole Holland

A thesis submitted to the faculty of The University of Mississippi in partial fulfillment of
the requirements of the Sally McDonnell Barksdale Honors College.

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ABSTRACT

For decades, Medicaid has been the largest public health insurance program for low-income individuals in the United States. The Affordable Care Act, signed into law by President Barack Obama on March 23, 2010, significantly changed eligibility requirements for Medicaid, expanding coverage to all low-income adults at or below 138% of the Federal Poverty Level. On June 28, 2012, the Supreme Court of the United States ruled in *National Federation of Independent Business v. Sebelius* that the Affordable Care Act's Medicaid expansion was unconstitutionally coercive but ruled that states remain eligible for expansion if they so choose. Thirty-seven states including Washington D.C., have expanded Medicaid eligibility under the Affordable Care Act. This research attempts to discover the benefits of Medicaid expansion through a literature review. There are mixed results regarding health outcomes. Economic outcomes are generally positive, producing net savings for state budgets and financially aiding low-income individuals to receive health insurance. Politically, the Affordable Care Act has been incredibly divisive. Democrats have generally supported Medicaid expansion, while Republicans have generally opposed it. Mississippi has not expanded Medicaid, but there is certainly a case for it. Mississippi is objectively one of the unhealthiest states in the country, and many low-income Mississippians have no realistic access to healthcare. Realistically, Mississippi will not expand Medicaid through the traditional legislative process; however, the research recommends that Mississippi could expand through a non-traditional method that is more politically feasible, such as a Section 1115 waiver.

Chapter 1: Introduction

By many measurements, the United States has the richest and strongest economy in the world. First, the United States' real Gross Domestic Product (GDP) value is roughly \$17 trillion, which is nearly \$7.5 trillion more than the next largest economy, China (World Bank, 2017). The United States has held a steady GDP growth since 2000, averaging roughly two percent. Since President Donald Trump's inauguration, GDP growth has exceeded expectations. By these indicators, one might assume that the United States' healthcare system is equally prestigious, but the opposite is true.

In an evaluation by the Kaiser Family Foundation, the United States' outlook for healthcare is grim, especially compared to other developed countries. For example, "the U.S. has the highest rate of deaths amenable to healthcare among comparable countries" (Peterson-Kaiser Health System Tracker, 2017). Basically, the healthcare that is technologically and readily available in the United States is not distributed equally amongst its citizens facing preventable deaths. Data from this dataset in 2006 and 2007 show that the United States' amenable mortality per 100,000 population was 96. The average mortality rate per 100,000 amongst comparable countries, such as the United Kingdom, Germany, and Japan, averages at 70 deaths.

Diseases are the leading cause of death in the United States, and even when weighted, the United States leads other comparable countries in deaths amenable due to health care. The United States has taken considerable measures to address these issues since 2010, but there is much work to be done, specifically on the state level. Since diseases are the primary cause of death in America, and Mississippi ranks first in

numbers of death per 100,000 population at 948.9 deaths per year. This thesis argues that there is a traceable link between lack of quality healthcare access and death; therefore, Medicaid expansion will produce better health outcomes in Mississippi. Thus, the research attempts to answer the question, what are the benefits of Medicaid expansion?

The goals behind Medicaid expansion and the ACA are generally two-fold: to expand health insurance coverage and to reduce the costs and improve the efficiency of healthcare. The goal of expanding health insurance is supported by the notion that if one has health insurance, one is more likely to receive necessary healthcare, no matter the condition. Medicaid expansion's initial goal, which is specifically providing low-income adults with healthcare access, has been overwhelmingly successful. As of February 2019, 36 states plus the District of Columbia (DC) have expanded Medicaid access to low-income adults at or below 138% of the FPL. As a result, Medicaid enrollment increased by 13.6 million people, or 35%, and 21 of these states saw increases of at least 25% (MacPac, 2018).

Although majority of states have expanded Medicaid, there are still millions of Americans that are in the "coverage gap," which is defined as the situation where one has an income above Medicaid eligibility but falls below the lower limit for receiving premium tax credits to purchase health insurance (Garfield, Orgera, & Damico, 2019). In non-expansion states, the median income limit for Medicaid eligibility is a mere 43%, far below the 138% limit mandated in expansion states. Data estimate the coverage gap's population is 2.2 million; 44% are white, 23% are black, and 24% are Hispanic (Garfield et al., 2019). Although most in the coverage gap are white, the minority groups are overly

representative, especially when considering that the black and Hispanic populations in the United States are small anyway.

The primary goal of Medicaid expansion, which is granting low-income adults health insurance, is only effective if physicians and healthcare centers accept Medicaid as payment. Over the past couple of decades, physician participation in Medicaid has been relatively stagnant. From 1996 to 2005, the percentage of physicians accepting Medicaid rose exactly one percentage point, from 51.1% to 52.1% (Cunningham & May, 2006). The number of office-based physicians accepting new patients rose to 68.9% in 2013, but this rate is much smaller than the new patients accepted using other insurers. As of 2013, 84.7% of physicians accepted new patients insured with private insurance; the same year, 83.7% of physicians accepted Medicare (Decker, Hing, & Jamoom, 2013).

The primary cause for this is generally attributed to “low Medicaid reimbursement rates relative to those of Medicare and private payers” (Cunningham & O’Malley, 2008, p. 17). Data show that “acceptance rates of new Medicaid patients were higher in states with higher Medicaid-to-Medicare fee-for-service fee ratios,” which simply refers to how much Medicaid reimburses physicians in comparison to Medicare (Decker, 2012, p. 1676). Although data show that Medicaid reimbursement rates are lower than other forms of insurance, still a majority of office-based physicians that accept Medicaid as payment. The gap in the uninsured rate between expansion and non-expansion states was 5.6% as of 2017 (Center for Budget and Policy Priorities, 2018). If physicians were not accepting new patients, the difference in the uninsured rate between the two cohorts of states would not be significant. Since physicians are generally

accepting new Medicaid patients, this suggests that the newly enrolled Medicaid recipients in expansion states do have access to primary care.

Mississippians are dying at a much faster rate than the average American. The life expectancy in Mississippi is 75 years old, nearly four years less than the national average (Kaiser Family Foundation, 2009). This disparity is mostly attributed to abundance of chronic illness throughout the state. Of the ten leading causes of death in Mississippi, nine are chronic diseases. According to the Centers for Disease Control and Prevention (CDC), Mississippi's heart disease mortality rate in 2017 was 231.6 per 100,000 people, the second highest in the United States (CDC, 2017). Cancer mortality rate in Mississippi is 183.1 per 100,000 people, which is nearly thirty-two points higher than the national rate (CDC, 2017). Similar figures exist for other ailments: second in cancer, stroke, and diabetes and third in chronic lower respiratory disease (CDC, 2017)

Compared to other Southern states, Mississippi's death rate in these chronic illnesses is alarmingly high. For example, Mississippi's heart disease mortality rate was nearly eight points higher than Arkansas', nearly 17 points higher than Louisiana's and nearly 60 points higher than South Carolina's (CDC, 2017). Mississippi slightly outperforms Kentucky in cancer mortality rates but is still nearly 12 points higher than the next Southern state, Louisiana.

Mississippi's susceptibility to these chronic illnesses derives from an intimate relationship with poverty. Low-income individuals in the United States "struggle to make ends meet; have few opportunities to achieve positive goals; experience more negative life events such as unemployment, marital disruption, and financial loss; and must deal with discrimination, marginality, isolation, and powerlessness" (Pampel, Krueger, &

Denney, 2010, p. 4). This phenomenon is mostly attributed to higher levels of risk behavior in these communities. Some of these behaviors include increased usage of tobacco products and the consumption of energy-dense, high fat food, which can lead to obesity, causing even more disease.

Although many Mississippians are suffering from chronic illnesses at an unprecedented rate, Mississippi's uninsured rate is twelve percent as of 2017, which is three percent higher than the national average (Kaiser Family Foundation, 2019). This rate does not reflect the necessity for access to health care. This phenomenon exists because the economic conditions are not present, and the lack of public funds have left roughly thousands of Mississippians without health insurance.

Most Mississippians rely on employer-based health insurance, representing forty-two percent of the populace (Kaiser Family Foundation 2017). Employer-based health insurance has been the most abundant form of access in the United States since President Franklin Roosevelt signed Executive Order 9250, establishing the Office of Economic Stabilization. During World War II, the United States had a massive labor shortage, forcing businesses to compete for workers. The Office of Economic Stabilization coerced businesses to freeze wages which prevented erratic inflation. Since these businesses could not raise wages to compete for workers, they chose to provide incentives such as health insurance. Due to this policy, today, there are 1.26 million Mississippians receiving health insurance through employer-based coverage.

The next biggest health insurance group is Medicaid, covering twenty-four percent of Mississippians (Kaiser Family Foundation, 2017). Medicaid, founded in 1965, "is the nation's public health insurance program for people with low income" (Rudowitz,

Garfield, Hinton, 2019, p. 1). It was created by an amendment to the Social Security Act of 1935 and is funded by United States' taxpayers. Medicaid functions as a partnership between the states and the federal government, granting the states flexibility to determine "covered populations, covered services, health care delivery models, and methods for paying physicians and hospitals" (Rudowitz et al., 2016, para. 2). Initially, every Medicaid program in each state was exceedingly selective, only covering low-income children deprived of parental support, their caretaker relatives, the elderly, the blind, and individuals with disabilities.

Although Medicaid participation has grown incrementally since its inception, its greatest enrollment period was after the Patient Protection and Affordable Care Act (ACA) was signed into law by President Barack Obama on March 23, 2010. As part of the ACA, Medicaid expanded eligibility to adults with incomes at or below 138 percent of poverty line (Rudowitz et al., 2016). In response, Attorneys General from across the country filed a lawsuit against the ACA, citing federal overreach and socializing healthcare. The case, *National Federation of Independent Business v. Sebelius*, traveled through the federal judiciary to the Supreme Court, and the Court in a 7-2 ruling held that the federal government could not coerce states into expanding Medicaid.

Luckily for the sake of this research, there are disparities in outcomes amongst low-income adults between states that have and have not expanded Medicaid through the ACA. The uninsured rates in Medicaid expansion states have decreased overall in comparison to non-expansion states, and as a result, low-income adults in Medicaid expansion states are more likely to seek treatment for any ailments, compared to low-income adults from non-expansion states. There is a growing number of research

suggesting that Medicaid eligibility during childhood has long-term impacts, “including reduced teen mortality, reduced disability, improved long-run educational attainment, and lower rates of emergency department visits and hospitalization later in life” (Rudowitz & Antonisse, 2018, para. 12). If expanding Medicaid eligibility, especially among children, is statistically linked to these benefits, then there is a strong case that expanding Medicaid yields better health outcomes.

To further analyze these health outcomes and determine if Medicaid expansion is a viable method of benefitting health outcomes, this research will be segmented into chapters addressing the most relevant aspects of Medicaid and the program’s expansion. Chapter 2 will contain a background review of Medicaid’s history that gives the reader relevant context for how Medicaid transformed into the program it is today. It will detail political actors that advocated for Medicaid’s creation while also detailing its opposition throughout the past decade. Chapter 3 will explain the methodology for analyzing the outcomes of expanding Medicaid. Chapter 4 will highlight the findings of my research. Chapter 5 will consist of a detailed discussion of the major implications of Medicaid expansion, along with policy recommendations and the conclusion. Chapter 6 presents the conclusion.

Chapter 2: Background Review

Expanding health care to vulnerable populations has been in the forefront of the American psyche since President Harry Truman's administration. One of his primary objectives was to insure that "all communities, regardless of their size or income level, had access to doctors and hospitals" (Truman Library & Museum, 2018, para. 1).

Although there were five primary tenets of his plan, the most ambitious was the proposed national health insurance plan, and its proposal was terribly unsuccessful. The American Medical Association (AMA) devised a relentless campaign against the proposition, characterizing the program as "socialized medicine" and characterizing the White House staffers under Truman as "followers of the Moscow party line" (Kirkendall, 1989, p. 251). Although his efforts were unsuccessful, President Truman showed the American public that issues surrounding health care were deserving of public attention.

After President Truman's initial efforts failed, President Lyndon Johnson addressed the health care issue again nearly two decades later when he signed into law the Social Security Amendments of 1965. Title XVIII created Medicare, a program that covered basic health care needs of Americans aged 65 and older. Some of those initial provisions included covering up to 90 days of hospital care, 100 days of nursing home care, and 100 home health care visits (Lyndon B. Johnson Presidential Library, 2018). Title XIX created Medicaid, a program that initially only gave Americans who received cash assistance health care coverage.

These entitlement programs were part of President Johnson's initiative called The Great Society. President Johnson first uttered the phrase in May of 1964 in a speech to

students at Ohio University in Athens Ohio: “And with your courage and with your compassion and your desire, we will build a Great Society. It is a society where no child will go unfed and no youngster will go unschooled.” Later that month, President Johnson clarified his goals, stating the “the Great Society rests on abundance and liberty for all” and its demand to “an end to poverty and racial injustice.”

Luckily, President Johnson had political clout to pass much of his proposed reforms. Republicans both in the presidential and congressional races were bludgeoned by the Democrats in 1964. President Johnson beat Republican Senator Barry Goldwater of Arizona in a landslide, winning 44 states plus D.C. Senator Goldwater only won his home state of Arizona and the Deep South states of Louisiana, Mississippi, Alabama, Georgia, and South Carolina, proving that his ideals of coded racism and contractionary economic policy were outside of the political mainstream. Democrats in the House of Representatives in 1964 gained 37 seats, giving them a two-thirds majority. Democrats in the Senate, which already held 66 seats prior to the election, gained two seats.

Before the 1964 elections, passing social programs like Medicaid was simply not possible. Democrats were heavily emboldened by these new supermajorities in both chambers, and this proved that Democratic ideals such as access to health care and the mitigation of poverty were acceptable, mainstream ideals. Along with these supermajorities, Democrats were gifted with another term of President Johnson. President Johnson was a masterful politician. His entry into public service began when he was elected member of the United States House of Representatives from Texas’ 10th district, serving as Congressman from 1937 to 1949. His success as a Congressman led him to

victory in the United States Senate election of 1948, and turmoil in the Democratic ranks in the Senate quickly allowed his ascension through leadership.

The Democratic majority leader and majority whip were both defeated in their respective reelection bids in 1950, and Senate Democrats elected then-Senator Johnson as their new whip. He quickly gained a reputation for his brash, assertive personality, and he was widely known to give Senators “the treatment,” described as “sweet talk, threats, and exaggerated facial expressions and body language” (United Senate Archives, 2018, para 13). His ascension from Democratic minority whip to President continually upgraded President Johnson’s political clout, and his ability to create political compromise sparked the creation of Medicaid.

Although expanded health care coverage was a quixotic proposal for past administrations and legislators, President Johnson’s cutthroat persona and the guidance from liberals in the House of Representatives and the Senate indicated that legislative action would likely occur. Unlike Medicare, which was revolutionary in its expansion of healthcare access to the elderly, Medicaid was intertwined in American society before its enactment. For example, the initial program that provided medical payment was authorized in 1950 through Social Security Amendments.

In 1960, Amendments titled the Kerr-Mills legislation authorized Medical Assistance to the Aged (MAA), providing federal funding to cover healthcare costs for the “indigent elderly” (Moore and Smith, 2008, p. 45). The legislation created a formula that distributed cash payments to state vendors for payments toward healthcare for the poor. This form of payments was an early innovation of the future Medicaid program that would be enacted in 1965 (Moore and Smith, 2008, p. 46). One important feature of

the legislation was that eligibility and benefit levels were determined by each state, meaning that wealthier states could enroll more recipients while poorer states could not compete. This unfortunate scenario created a system where 62% of recipients came from five states. Since state participation was voluntary, enrollment was meager and did not meet its initial goal. The legislation predicted covering 10 million people, but the program only covered 264,687 people by 1965.

In order to correct the problems displayed in the Kerr-Mills legislation, Congressman Wilbur Mills, namesake of the Kerr-Mills legislation, introduced the Social Security Amendments in March of 1965, which consisted of both Medicare and Medicaid. The Amendments easily passed the House of Representatives by a 307-116 vote. The Senate also easily approved the Amendments by a vote of 70-24. Opposition to the Amendments was shared by some Republicans and several Southern Democrats.

Medicaid was created as a reform to the Kerr-Mills legislation, but much of the legislative attention was focused on the creation of Medicare. Despite the lack of public focus on the Medicaid program, its creation was important for institutionalizing provisions and standardizing services provided by the Social Security Act. Some of these requirements included “statewideness, use of merit personnel system, and the right of recipients to fair hearing provisions” (Smith and Moore, 2008, p. 48). Like Kerr-Mills, Medicaid was voluntary, but states that participated were forced to provide public assistance to three categories: the blind, families with dependent children, the permanently and totally disabled, and anyone receiving assistance under the state plans.

Over the past several decades, federal and state lawmakers have approved measures to further expand Medicaid coverage to different portions of the uninsured

population. The original law from 1965 mandated that states extend eligibility to poor single parents and children receiving benefits through the Aid to Families with Dependent (AFDC) program, but eligibility quickly expanded (Paradise, Lyons, & Rowland, 2015). In 1967, amendments were introduced to the Social Security Act granting states the authority to give Medicaid coverage to poor children in two-parent households that did not qualify for welfare. This action created the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program that focuses on sustaining the health and development of poor children that are prone to poor health due to their socioeconomic status (Paradise et al., 2015.)

Republican control of government in much of the 1970s and 1980s forced Medicaid reform into the spotlight. For example, President Gerald Ford proposed to consolidate Medicaid along with 15 other categorical federal healthcare programs into a \$10 billion block grant to the states (Gerald Ford Presidential Library, 2019). This was mostly an effort to eliminate much of the federal oversight mandated by Medicaid and return much of the responsibility to the individual states. The primary proposition was eliminating the state matching requirements, but the proposition failed.

President Ford's proposed Financial Assistance for Health Care Act was not adopted, but this did not stop efforts to replace Medicaid as a block grant program. One of President Ronald Reagan's top legislative priorities was reforming Medicaid. President Reagan was elected as a conservative to decrease what was seen as outrageous federal spending, and by 1980, federal spending for both Medicare and Medicaid had eclipsed \$49 billion. In response, the Reagan Administration and Congress worked on two major initiatives to reduce Medicaid spending. Congress generally agreed with the Reagan

Administration's proposal that Medicaid spending should be generously cut; therefore, federal matching payments were reduced by three percent in 1982, four percent in 1983, and 4.5 percent in 1985 (Etheridge, 1983). These reductions had clear impacts on enrollment; by 1983, fewer than 40% of the nation's poor were enrolled in Medicaid (Sparer, 2015).

Although the Reagan Administration was successful in reducing Medicaid funding and restricting the program's eligibility requirements, several lawmakers started initiatives to refocus the program's aim in expanding coverage to especially vulnerable populations. For example, Democratic governors in the South pushed for policy that would reduce the high infant mortality rates within their respective states. This effort led to the creation of the Southern Regional Project on Infant Mortality, and this task force saw Medicaid expansion as a reasonable method to mitigate the infant mortality crisis.

This task force aided lawmakers in recommending steps to eliminate much of the health disparities in the South, and policy initiatives followed soon after the group's first meeting in 1984. For example, Florida expanded Medicaid coverage to all categories of pregnant women and children in 1986 (The Southern Regional Project on Infant Mortality, 2005). Georgia's General Assembly in 1984 appropriated funds to double physician reimbursement for obstetric services provided to Medicaid patients (The Southern Regional Project on Infant Mortality, 2005). Both Kentucky and Louisiana expanded Medicaid eligibility to medically-needy pregnant women and children in 1984.

The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) extended Medicaid eligibility significantly. The Act mandated states to expand eligibility to all children under the age of six in families with incomes of less than 133% of the Federal

Poverty Level (FPL) (Leininger, 2009). Further Medicaid expansion was enacted a year later through OBRA 1990, “requiring states to gradually expand Medicaid eligibility to children of all ages living in families with incomes at or below 100% FPL” (Leininger, 2009, p. 24). Although beneficial for the poor, state lawmakers were generally opposed to these expansions. Beginning in July of 1990, a recession stagnated the United States’ economy. The consolidation of decreased tax revenue due to the recession and the expansion of Medicaid forced state lawmakers to cut spending for other social welfare programs to dodge budget deficits (Sparer, 2015).

Increasing frustrations with the heightening costs of Medicaid forced lawmakers in the early 1990s to avoid Medicaid expansion as a method to expand health insurance. In response, the newly inaugurated President Bill Clinton proposed a new health care initiative in 1993 which was dubbed “Hillarycare,” an ode to President Clinton’s wife Hillary and her position as chairwoman of the Task Force on National Health Care Reform. The bill, introduced as the Health Security Act, would have primarily authorized the federal government to control the costs of healthcare, such as doctor bills and insurance premiums. This regulation was an effort to lower costs commonly associated with the American healthcare system, and it could have possibly reduced the need for any new Medicaid expansions.

Although the bill was popular in the first year of President Clinton’s term, support for Hillarycare quickly faded after the combination of economic conditions improving in 1993 and the lack of union support due to the new North American Free Trade Agreement (NAFTA). Hillarycare’s quick demise coincided with an ample increase in Medicaid enrollment. In 1992, 35.8 million people were enrolled in Medicaid. By 1995,

Medicaid enrollment had ballooned to 41.7 million (Kaiser Commission on Medicaid Facts, 2001). One reason for this can be attributed to another effort by the Clinton Administration. In 1997, President Clinton authorized the State Children's Health Insurance Program (SCHIP, later stylized as CHIP). This program, authorized by the Balanced Budget Act (BBA) of 1997, authorized block grants for states to either invest in separate health insurance programs or expand Medicaid. Seventeen states used federal dollars to finance a separate state-run health insurance program, seven states (plus the District of Columbia) consolidated CHIP with their existing Medicaid programs, and 26 did a combination of both (Sparer, 2015).

President George W. Bush's Administration made significant efforts to expand access to Medicaid. For example, waivers administered by the Department of Health and Human Services increased states' flexibility in expanding Medicaid. These waivers granted to different states across the country expanded health insurance coverage to 2.6 million low-income workers and their families through an expansion in Medicaid and CHIP programs (Sparer, 2015). This decision had measurable impacts on enrollment. From 2000 to 2003, enrollment in CHIP programs across the country increased from 3.3 million to 5.8 million, which is a 75 percent increase (Kaiser Family Foundation, 2019). From 2000 to 2008, Medicaid enrollment spiked from 34.5 million to 47.7 million (MacPac, 2018).

Although the Bush Administration was responsible for significant gains in Medicaid and CHIP enrollment, there were still major blemishes in the American healthcare system. Health care costs were rising significantly, and the uninsured rate was growing significantly. By 2010, the uninsured rate peaked at 18.2%. In 2008, then-

candidate Barack Obama made healthcare reform a central issue of his campaign, and he was determined to pass the most comprehensive healthcare reform since President Johnson's creation of Medicare and Medicaid. Like President Johnson in the 1964 elections, President Obama was emboldened to take considerable action after the 2008 election. The Democrats kept their majority in the House of Representatives, and Senate Democrats formed a filibuster-proof majority. This was likely the only scenario where a healthcare reform bill could survive given Republican opposition.

On July 15, 2009, the Senate Health, Education, Labor and Pensions Committee approved the Affordable Health Choices Act, ushering in the first movement of President Obama's healthcare initiative. By November 2009, the House of Representatives passed the Affordable Care Act by a 220-215 vote. 219 Democrats voted in favor, and 39 voted against it. The Republicans held together a unified front against the bill except for Congressman Joe Cao, Republican from Louisiana. With Democrats leading both chambers of Congress and President Obama in the White House, a final version of a healthcare bill was certain to pass. However, in January 2010, the vacant Senate seat vacated by Senator Ted Kennedy was won by Republican Scott Brown, giving Republican Senators a chance to filibuster the final vote for the ACA. In response, then-Senate Majority Leader Harry Reid sent a letter to then-Senate Minority Leader Mitch McConnell notifying him and the Republican caucus that Senator Reid would pass the final Senate version through budget reconciliation, a process that only requires 51 votes (Keneally, 2017).

On March 23, 2010, President Obama signed the ACA into law. According to the website that was authorized by the legislation, the ACA has three primary goals. First, it

provides consumers with incomes between 100% and 400% of the FPL with so-called “premium tax credits” to purchase affordable health insurance plans. Second, it aims to financially support health care innovations that lower the cost of healthcare in general. Third and most important for the topic of this research, it expands the Medicaid program significantly, covering adults with income at or below 138% of the FPL.

The expectations of expanding Medicaid across all 50 states quickly failed. Shortly after the ACA was enacted, 26 states, several individuals, and the National Federation of Independent Business, which is a non-profit organization that works to defend the rights of small business owners, filed a lawsuit in Federal District Court challenging the constitutionality of both the Medicaid expansion and the individual mandate. The individual mandate, an important aspect of the law expanding private health insurance, mandates most Americans to acquire “minimum essential” health insurance coverage.

The lawsuit against the ACA was quickly appealed to the United States Supreme Court. Chief Justice John Roberts, joined by Associate Justices Stephen Breyer and Elena Kagan, ruled that Part IV of the ACA’s Medicaid expansion violated the Constitution by coercing states to either accept the Medicaid expansion or have its Medicaid funds stripped altogether. The expansion specifically violated the Constitution’s Spending Clause: the legitimacy of it rests on the principle that states must voluntarily accept terms of state-federal programs. The Supreme Court did allow, however, states to voluntarily expand Medicaid, and so far, 37 states (including Washington D.C.), have expanded Medicaid.

Since President Trump's inauguration, the Republican-led House of Representatives and Senate have unsuccessfully attempted to repeal the ACA. On March 6, 2017, House Republicans released their version of "repealing and replacing" the ACA called the American Health Care Act (AHCA), but Speaker of the House Paul Ryan pulled the bill on March 24 due to intraparty conflict and lack of support. On June 22, 2017, Senate Republicans released their version of repeal and replace, the Better Care Reconciliation Act (BCRA), and a notable feature of the bill was deep cuts to Medicaid. In the early hours of July 28, 2017, Republican Senator John McCain joined fellow Republican Senators Susan Collins and Lisa Murkowski in voting against the BCRA, stunning both the chamber and the nation.

Since this infamous vote, the Trump Administration has continued to vociferously battle the ACA in both small and large facets. For example, beginning in 2013, the Obama Administration collaborated with the private sector, such as Uber and Lyft, and with faith-based organizations like the United Methodist Church to publicize the ACA and Medicaid enrollment (Center on Budget and Policy Priorities, 2018). This is especially significant because the ACA's success is dependent on enrollment from young, diverse, and healthy individuals. Since August of 2017, the Trump Administration has not indicated that this program will continue.

Beginning in January of 2018, the Centers for Medicare and Medicaid Services (CMS) issued a memo to allow states to revoke Medicaid coverage from low-income adults if they are not working or participating in work-related activities (Center on Budget and Policy Priorities, 2018). That month, the Department of Health and Human Services (HHS) approved the first of these waivers that was filed by the Commonwealth

of Kentucky. The policy permits Kentucky's Medicaid division to force Medicaid beneficiaries to attain a job or to become involved in some sort of work-related activity (Center on Budget and Policy Priorities, 2018). As of May 2018, CMS approved similar waivers for Arkansas and Indiana.

Perhaps the greatest jeopardy facing the ACA and Medicaid expansion as a whole has been a federal lawsuit filed by 18 attorneys general and two Republican governors in the Northern District of Texas. The plaintiffs in this case, *Texas v. United States*, argue that the ACA is unconstitutional because the case upholding the ACA's requirement to carry insurance, *National Federation of Independent Business v. Sebelius*, is also unconstitutional. The plaintiffs argue that as a result of the Tax Cuts and Jobs Act of 2017, which lowered the individual mandate tax to zero percent, the individual mandate is no longer enforceable. In December of 2018, Federal District Judge Reed O'Connor wrote in a partial summary judgement that the "Individual Mandate can no longer be fairly read as an exercise of Congress's Tax Power and is still impermissible under the Interstate Commerce Clause--meaning the Individual Mandate is unconstitutional."

Judge O'Connor's ruling has since been appealed to the United States Court of Appeals for the Fifth Circuit, and the Trump Administration has promised to continue enrollment under the Affordable Care Act. The primary problem that pundits and legal scholars see in this ruling is that deeming the ACA unconstitutional solely because of the supposed unconstitutionality of the Individual Mandate deeply jeopardizes Medicaid expansion programs authorized by the ACA.

The plaintiffs in the case sought to imperil the ACA based on the legal principle of “severability,” which argues that if one clause of a statute is found unconstitutional, then the entirety of the statute in question is unconstitutional. Severability is a valid legal argument, just not in this specific case. According to Jonathan Adler and Abbe Gluck, seasoned law professors at the Case Western Reserve School of Law and Yale Law school, respectively, the Justice Department (DOJ) does not clearly understand the theory of severability in their defense of the plaintiffs in the case. The professors both write in an Op-Ed to *The New York Times* that congressional intent is the core tenet of severability (Adler & Gluck, 2018). If the United States Congress’ intent was to completely repeal the ACA, they would have voted so. Many members of Congress, even staunch conservatives from the Republican Party, recognize and support important aspects of the ACA, including protections for those with pre-existing conditions, individuals remaining on their parents health insurance until age 26, and Medicaid expansion. If jeopardizing those clauses in the ACA was on the forefront of their agenda, they would have likely voted to do just that.

The ACA’s survival is uncertain, especially after this new litigation in the federal courts. Will the United States Court of Appeals for the Fifth Circuit uphold Judge O’Connor’s judgement? Will Republican leaders in the newly inaugurated 116th Congress continue to feel emboldened by the DOJ’s hawkish litigation against the ACA? There is no clear answer, but there are multiple signs that fighting against the ACA is an unpopular policy initiative. The most recent polling suggests that 53% of American adults view the ACA favorably, while only 40% view it unfavorably (Kaiser Family Foundation, 2018). This favorability rate is significantly higher than previous years

earlier. Just in November 2016, favorability for the ACA was only 45%. Interestingly, President Trump's increased attacks on the ACA have correlated positively with the ACA's favorability. From April to June of 2017, the ACA's favorability rose from 46% to 51%. This was likely due to Congressional Republicans' efforts to repeal the ACA that summer through various measures.

Favorability specifically for Medicaid expansion has also risen significantly since President Trump's election. According to polling from the Kaiser Family Foundation, those that viewed Medicaid expansion through the ACA very favorably rose from 45% to 51% as of November 2018. The greatest percentage increase amongst the subgroup was with Independents, rising to 49% in November 2018 compared to 39% in November 2016; the next highest was among Democrats, rising from 62% to 69% in the same time period; and the only subgroup where support dipped was from Republicans, dropping from 29% to 24% in the same time period.

Although Republican support has significantly waned in the past two years, Medicaid expansion has been adopted in deeply conservative states since President Trump's election. In November 2018, voters in Idaho, Nebraska, and Utah approved ballot initiatives to expand Medicaid through the ACA. Idahoans voted overwhelmingly for expansion with 62% of voters in support. Only two years prior, 59.2% of Idahoan voters voted for then-candidate Trump, a staunch opponent of Medicaid expansion and the ACA writ large.

Chapter 3: Methodology

Using literature review, the researcher gained insight into Medicaid expansion and its relationship with health outcomes, politics, and socioeconomic effects. The researcher performed this review by utilizing Google Scholar and One Search. With regard to health outcomes, the researcher specifically searched with indicators to collect literature highlighting the effects of Medicaid expansion. The researcher used this literature to gain insight on expanding Medicaid and its effect not directly associated with health outcomes; its effect on the economy and politics are examples.

The sources gathered are mostly scholarly peer-reviewed articles. To efficiently utilize these databases, the researcher used these indicators in Google Scholar: *Medicaid*, *Medicaid and economy*, *Medicaid and politics*, *Medicaid effects*, *Medicaid and health outcomes*, *Medicaid and Mississippi*; *Medicaid expansion*; *Medicaid and elections*; *Medicaid and healthcare access*; *Medicaid history*; *Medicaid and the Supreme Court*; *Medicaid and spending*; *Medicaid and poverty*; *Medicaid and chronic disease*; *Medicaid eligibility*; *Medicaid and low-income*; and *Section 1115 Medicaid waivers*.

Once the researcher compiled the necessary content, the researcher compiled each of the relevant articles into diversified groups: case studies, health outcomes, politics, socioeconomic effects, and miscellaneous, which mostly evaluates the effectiveness of Medicaid as a whole despite expansion. In the case studies group, the researcher identified peer-reviewed articles that contained research regarding the successes or lack thereof of Medicaid expansion in expansion states, including Arkansas, Oregon, and Pennsylvania. Articles concerning health outcomes comprise most of the literature; these

articles evaluate health outcomes in several ways, like comparing outcomes between expansion and non-expansion states and evaluating Medicaid expansion on quality of care concerning illnesses like cancer and kidney failure. Articles concerning the politics of Medicaid expansion examine why states' politicians may or may not be inclined to accept additional funding. These articles track the political capital of expansion while also weighing whether expansion proposals are politically feasible. The articles regarding the socioeconomic effects of Medicaid expansion aim to explain how the accessibility of government health insurance can alleviate socioeconomic suffering amongst low-income adults. The miscellaneous articles either have its own unique distinction or a mixture between the categories listed above. For example, one article is a general literature review of Medicaid by the Kaiser Family Foundation; another focuses on Medicaid's relationship with private health insurance.

Chapter 4: Findings

Health Outcomes

One of Medicaid's goals is expanding positive health outcomes to low-income adults, but literature provides mixed suggestions. Low-income adults in expansion states are more likely to have a usual source of health care (Han, Nguyen, Drope, Jemal, 2015). This is consistent with the previous findings that a majority of physicians still accept new Medicaid patients. Low-income adults in expansion states more frequently utilize preventive healthcare measures compared to low-income adults in non-expansion states, such as dental check-ups, routine physical checks, flu vaccinations, and blood pressure checks (Han et al., 2015).

Medicaid expansion is also associated with more frequent reports of better self-reported health (Sommers, Baicker, & Epstein, 2012; Baicker, Taubman, Allen, et al., 2013). Medicaid coverage was associated with an "increase in the proportion of people who reported that their health was the same or better as compared with their health 1 year previously" (Baicker et al., 2013, p. 1717). The same study, however, only chronicles a significant improvement in the mental health component, but not the physical component. Despite this, Medicaid expansion is associated with a "significant increase in rates of 'excellent' or 'very good' health" (Sommers et al., 2012, p. 1029).

Medicaid expansion is also associated "with a significant reduction in adjusted all cause mortality" (Sommers et al., 2012, p. 1025). The rate of mortality was relatively reduced by 6.1% and was greatly concentrated among older adults, nonwhites, and residents of poorer counties. The mortality reductions were most concentrated among

adults between the ages of 35 and 64, which is the target range of Medicaid expansion through the ACA (Sommers et al., 2012). Decreases in mortality rates were significantly higher in counties with higher poverty rates.

One of the groups that benefits the most from Medicaid expansion is individuals with chronic conditions. Statistics indicate that roughly one in three uninsured adults has a chronic health condition (Clemans-Cope, Coughlin, Resnick, Long, & Yemane, 2013). As of 2017, 27.4 million people remain uninsured; this means that nearly 10 million of those uninsured suffer from chronic conditions. Data show that low-income adults with a chronic disease have much to gain through Medicaid. For example, adult Medicaid beneficiaries with a chronic condition were more likely than those without insurance to utilize care (89.3% vs 58.4%) and less likely to report unmet medical care (6.9% vs 23.3%) or for prescription drugs (Clemans-Cope et al., 2013). More specifically, among uninsured individuals, “38.4% had not been seen even once in the outpatient setting in the past year, compared with only 8.2% of those with Medicaid” (Christopher, McCormick, Woolhandler, Himmelsstein, Bor, and Wilper, 2016, p. 66).

To more specifically evaluate the impact of Medicaid coverage on chronic conditions, it is important to focus on the impact it has on prevalent chronic diseases. One example is cardiovascular disease (CVD). CVD is the leading cause of death in the United States, claiming nearly 650,000 lives in 2016 (CDC, 2017). CVD refers to a number of ailments, including heart and blood vessel diseases, heart attacks, strokes, heart failure, arrhythmia, and heart valve problems. One of the leading causes of heart disease is hypertension, also known as high blood pressure. Researchers found that people with evidence of hypertension that had Medicaid coverage had greater odds of

both being previously diagnosed and having their hypertension controlled (Christopher et al., 2016). In another study, however, there was no evidence that Medicaid coverage had any significant effect “on the prevalence or diagnosis of hypertension or high cholesterol levels or on the use of medication for these conditions” (Baicker et al., 2013).

Diabetes, the seventh leading cause of death in the United States as of 2016, disproportionately affects low-income adults. Research shows that poverty “is significantly associated with an increase in type 2 diabetes incidence, delayed diagnosis of diabetes, and inadequate diabetes care and management” (Chang, Chen, Chen, et al., 2012, p. 2286). Medicaid coverage is associated with mixed health outcomes regarding the management of type 2 diabetes (Christopher et al., 2016; Baicker et al., 2013). For example, Medicaid coverage significantly increased the probability of a diagnosis of diabetes while simultaneously increasing the probability of using medicine to manage the condition, but in another study, it is not associated with awareness or control of diabetes (Christopher et al., 2016; Baicker et al., 2013). Many who suffer from type 2 diabetes must change diet and lifestyle to fully treat the condition, so this may be the reason that it is not as manageable as other chronic conditions.

Medicaid expansion is also associated with reducing infant mortality rate (Bhatt & Beck-Sagué, 2018). From 2010 to 2016, the infant mortality rate in both expansion and non-expansion states declined; however, “the decline in Medicaid expansion states was more than 50% greater than in non-Medicaid expansion states” (Bhatt et al., 2018, p. 566). This research shows that the greatest decline in the infant mortality rate was among African-American infants. Reducing the infant mortality rate is an especially important

goal for Mississippi's lawmakers. As of 2017, Mississippi has the highest infant mortality rate in the United States (CDC, 2019).

Economic Outcomes

Funding for Medicaid expansion primarily stems from the federal government. Under the ACA, the federal government paid 100% of Medicaid expansion between 2014 and 2016; the federal share dropped to 95%, 94%, and 93% in 2019. The federal share will drop to 90% in 2020 and each year onward. Analysis shows that Medicaid expansion was associated with "net savings for state budgets while the federal was paying the full cost of expansion enrollees, since expansion allowed states to spend less in other areas" (Cross-Call, 2018, p. 2). Using specific states as case studies verifies this claim. For example, Arkansas is estimated to produce net savings each year through fiscal year 2021, totalling \$444 million in savings from 2018-2021 (The Stephen Group, 2016). Montana has produced net savings since 2016 because the state receives a higher match rate for some Medicaid beneficiaries than previous match rates (Bureau of Business and Economic Research, University of Montana, 2018). Since Virginia adopted Medicaid expansion in June 2018, the Commonwealth is estimated to save \$421 million in its first two years (Overview of the Governor's Introduced Budget, 2018).

Although there is growing evidence that states can produce net savings through Medicaid expansion, the program is expensive regardless. Growth in Medicaid spending has been steep, especially during recessions (Iglehart and Sommers, 2015). CMS projects that spending will eclipse roughly \$919 billion by 2023. Most of this new spending, however, is attributed to increased enrollment due to the ACA. Per-enrollee spending has been relatively stable since 1998 (Iglehart et al., 2015).

On a microeconomic level, Medicaid expansion is associated with significantly decreasing out-of-pocket costs for low-income families' healthcare (Glied, Chakraborty, Russo, 2017). Families with incomes below 138% of the FPL spend 73% of their monthly budget on housing, food, and transportation, with little left to allocate toward potential healthcare spending (Consumer Expenditure Survey, 2015). Research suggests that families living in expansion states are 11% less likely to have any spending on healthcare (Glied et al., 2017). This suggests that low-income families will have more disposable income to spend on necessary expenditures like housing, food, and transportation.

Research suggests that low-income individuals covered by Medicaid are much less likely to forego necessary healthcare treatment because of cost (Sommers et al., 2012). Also, Medicaid coverage is associated with reductions "in financial strain from medical costs, according to a number of self-reported measures" (Baicker et al., 2013, p. 1718). Specifically, catastrophic expenditures, which are defined as out-of-pocket costs that exceed 30% of one's income, were virtually eliminated by Medicaid coverage (Baicker et al., 2013).

Political Outcomes

Since the passage of the ACA, Medicaid expansion has been highly politicized. Initially, acceptance of Medicaid expansion followed party lines; state governments controlled by Democrats were in favor, while state governments controlled by Republicans were staunchly opposed (Iglehart et al., 2015). Medicaid is a convenient target for conservative lawmakers "because it represents many of the ideological right's lightning rods for outrage: federal control, major government spending, a meanstested

program that can be seen as rewarding poverty, and now a manifestation of healthcare reform” (Sommers & Epstein, 2011, p. 101). Is this position justified? There are arguments for both. There is certainly “a fiscal bind in which Medicaid plays a large role, and several features of the ACA seem to worsen the budgetary outlook” (Sommers et al., p. 101). The fiscal bind, however, is mostly the federal government’s burden. A joint federal-state program, Medicaid accounts for 21% of state spending nationwide, but the federal government funds 60% of that cost, so Medicaid actually consumes around 12% of state budgets (National Association of State Budget Officers, 2010).

There is a valid reason for states’ wariness on the issue: Medicaid expansion is designed as countercyclical, which means that enrollment and spending increase when there is an economic downturn. When the ACA was signed by President Obama, the United States was in the worst economic downturn since the Great Depression. Economists generally agree, however, that countercyclical programs are beneficial during an economic downturn; these programs “protect household income and promote consumption that fuels the economy” (Sommers et al., p. 100).

Public polling in the months before the 2010 midterm elections suggested that attitudes regarding the ACA were a central campaign issue. For example, when Americans were asked how important several issues were, “more than [four] in [ten] Americans (41[%] to 49%) said that healthcare or healthcare reform would be extremely important” (Blendon & Benson, 2010, pp. e30(2)-e30(3)). 71% of respondents before the 2010 midterm elections said a candidate’s position on the ACA would affect their congressional vote (Blendon et al., 2010). Although polling was suggestive that voters were highly attentive to the new health care law, voters were generally apathetic on how

the federal government could actually help Americans through the ACA. A majority (56%) of Americans said they had little to no confidence in the federal government's ability to fix the United States' healthcare problems (Blendon et al., 2010).

In a referendum on the ACA and President Obama's policy initiatives writ large, Republicans completely vanquished Democrats in the 2010 midterm elections. Republicans gained majority control in the House of Representatives, flipping 63 seats. Although the United States President's party typically loses seats in midterm elections, this was the largest swing in the House of Representatives since 1948 and the largest gain Republicans had made in the House of Representatives since 1938. Republicans gained six seats in the Senate, but Democrats still kept their majority with 51 seats plus two Independents who caucused with Democrats.

Since the decision in *National Federation of Independent Business v. Sebelius* ruling that Medicaid expansion was optional, evidence shows that Republican governors are much less likely than Democratic governors to expand Medicaid (Barrilleaux & Rainey, 2014). Evidence also shows that states with Republican-dominated legislatures oppose expansion (Barrilleaux et al., 2014). Of the 14 states that have not expanded Medicaid, only three of those states have Democratic governors. North Carolina was the only non-expansion state to have a Democratic governor before the 2018 elections. Although there is a clear trend between governors' party identification and their willingness to accept expansion, there are some clear outliers. One example is North Dakota. The state is overwhelmingly Republican; it has been governed by Republican governors since 1992, and the last time the state voted for a Democratic presidential candidate was in 1964 when President Johnson overwhelmingly captured the nation's

vote. Despite the state's embrace of conservatism over the past several decades, Republican Governor Jack Dalrymple publicly supported Medicaid expansion in 2012. In an official statement, Governor Dalrymple said the following:

"I know some of you are not excited about expanding Medicaid, and I still share some of your thoughts. It bothers me that some people who can work will become more dependent on government. I hate that. But we have to remember the single parent with three children. Between work and child care, a parent in that situation sometimes can't work enough hours to get insurance."

Another example is Arizona. In 2013, Republican Governor Jan Brewer vociferously supported Medicaid expansion and signed it into law despite heavy opposition from legislators in her own party. One of the methods Governor Brewer used was "vetoing a stream of unrelated bills to pry her priority loose from Republicans, and she brought them back into special session" (Cheney and Millman, 2013, para. 4). Governor Brewer's generally positive tone toward expansion was not reciprocated among all Republican governors accepting expansion. One example was Republican Governor Chris Christie, who was a staunch opponent of the ACA as a whole. In his budget address at the New Jersey Statehouse in 2013, Governor Christie said the following regarding his decision to accept Medicaid expansion:

"Let me be clear, I am no fan of the Affordable Care Act. I think it is wrong for New Jersey and for America. I fought against it and believe, in the long run, it will not achieve what it

promises. However, it is now the law of the land. I will make all my judgments as governor based on what is best for New Jerseyans.”

There is no evidence that state governors are more likely to accept Medicaid funding if the states’ citizenry is highly in need of health insurance (Barilleaux et al., 2014). For example, Mississippi’s citizens are, in general, much poorer than the average American citizen. Mississippi’s unemployment rate is ranked 44th in the nation, and since health insurance is offered by many employers, Mississippians generally have fewer opportunities to become insured. Mississippi’s poorness directly correlates with the negative health outcomes many Mississippians endure, and according to the findings that Medicaid coverage is better than no coverage at all, Mississippians would greatly benefit from expansion. Despite this fact, Governor Phil Bryant has defiantly opposed expansion since day one. Governor Bryant’s opposition is rooted in his disdain for federal overreach, and he fears that expansion’s costs will be too high (Benen, 2014; Steenhuysen, 2013).

Unlike Republican governors, Democratic governors have been overwhelmingly supportive of Medicaid expansion. All states with Democratic governors excluding North Carolina have expanded Medicaid. Wisconsin is an interesting case, though. The state did not expand Medicaid under the ACA guidelines, but the state’s BadgerCare Medicaid program covers all legal residents with incomes under the FPL. The difference is that Wisconsin is only receiving the federal match rate of 58.5%, while the state is paying the remaining amount. If Wisconsin were to expand under the ACA guidelines, the federal government would match 90%, but only for newly eligible enrollees. Wisconsin’s newly elected Governor, Democrat Tony Evers, has signaled his support for Medicaid

expansion under the ACA. In his first day as Governor, Evers signed two executive orders, one of which was aimed at Ever's campaign promise of expanding Medicaid. The order specifically called for Wisconsin's Department of Health Services to develop a plan "to ensure that more Wisconsinites have access to affordable, quality health care, while saving Wisconsin taxpayer dollars, by expanding Medicaid eligibility" in Wisconsin (Sommerhauser, 2019, para. 3).

There is growing evidence that Medicaid expansion is becoming less partisan of an issue. For example, in November 2018, voters in Idaho, Nebraska, and Utah voted to expand Medicaid under the ACA. Idaho's Proposition Two garnered a significant amount of support with 62% of the vote. Outgoing Republican Governor C.L. "Butch" Otter gave a surprise endorsement of the law, saying that "reducing the number of uninsured Idahoans would have a ripple effect of stabilizing struggling rural hospitals and public health clinics" (Goldstein, 2018, para. 10). In a staunch rebuke against the state legislature's measures to reject expansion, Nebraska voters approved Initiative 427 by a 53% vote to expand Medicaid, which is estimated to cover 87,000 low-income residents (Goldstein, 2018). Utah voters approved Proposition 3 with a 54% vote; Medicaid expansion is estimated to cover 150,000 residents in Utah.

Chapter 5: Policy Recommendations

Due to Affordable Care Act guidelines, there are a small number of policies that Mississippi could choose regarding its future with Medicaid. These policies can be divided into three categories: non-expansion, expansion, and a Section 1115 waiver. Mississippi's current trajectory is toward non-expansion: Governor Bryant is adamantly opposed to expansion, and unless a Democrat wins the governorship in 2019, the next governor will likely oppose expansion, as well. If a Democrat does not win the governorship, voters could opt to pass expansion through a referendum, like Idaho, Nebraska, and Utah voters did in the 2018 elections. Another policy option is a Section 1115 waiver which provides "states an avenue to test new approaches in Medicaid that differ from what is required by federal statute" (Antonisse, Hall, Hinton, Musumeci, Rudowitz, 2019, para. 1).

Non-expansion

This is the status quo policy recommendation. Mississippi could continue current eligibility levels. The maximum income eligibility level as a percent of the Federal Poverty Level (FPL) for Mississippi children in the Medicaid/CHIP program is 214%. The Medicaid and CHIP income eligibility limits for pregnant women are 199% of the FPL. The strictest income eligibility requirements are for adults. In a family of three, parents can receive Medicaid coverage if their income is 27% of the FPL, which is an annual income of \$5,610. Adults without children do not qualify for Medicaid regardless of their income.

If non-expansion continues to be the preferred policy, there are still many that benefit. There were 787,049 individuals enrolled in Medicaid as of 2015 (Mississippi Division of Medicaid, 2016). As the literature suggests, these people receive medical care that is beneficial to their health and personal economic outcomes. The highest percentage of populations served is children, which are particularly vulnerable. Mississippi's Medicaid enrollment has also increased significantly despite non-expansion. In 2010, 690,737 were enrolled. Enrollment by 2015 had increased by 13.94%.

Despite growing evidence that Medicaid coverage produces more positive health outcomes than no coverage at all, non-expansion is a popular policy proposal, and Mississippi voters writ large will likely vote for candidates that do not support expansion. For example, Governor Bryant won reelection in 2015 by a landslide margin of 66.4% to 32.2%. Governor Bryant has been particularly vocal about his opposition to Medicaid expansion, and his supporters have likely supported him on this since healthcare is typically a popular campaign issue. One primary reason this is a popular policy decision is Governor Bryant's worries are valid: state budgets are in dire straits (Sommers et al., 2011). Although 90% of expansion would be funded by the federal government, Mississippi would be responsible for funding the remaining 10%.

Proponents of non-expansion, including Governor Bryant and Republican lawmakers in Mississippi writ large, cite these dire budget straits as their main premise against expansion. Governor Bryant called expansion a "fool's errand" several years ago because it would lead to "cuts to education and infrastructure," but that has not stopped lawmakers from making these cuts anyway (Pittman, 2019, para. 21). For example,

Mississippi's Republican lawmakers in 2016 eliminated the corporate franchise tax. This will cut \$400 million in tax revenue over ten years.

Despite continued support for candidates that reject Medicaid expansion, Mississippi voters may become jaded by non-expansion. Throughout the next decade, Mississippi will lose \$11.1 billion in federal funds if the state continues with the non-expansion policy. There is a general reluctance among the electorate of accepting federal funds, but Mississippi's economy along with its healthcare infrastructure is crumbling. If Mississippi's lawmakers are genuinely concerned about revamping the economy, then non-expansion is not a viable policy option. Frankly, people who do not have basic medical needs met cannot be productive in a work-based society. Chronic diseases are especially hindering, and there are thousands of adults in the coverage gap. Again, there is evidence that Medicaid expansion produces positive health outcomes. These positive health outcomes, along with financial security that Medicaid coverage gives individuals, could produce an environment where more people can work more easily.

Expansion

Mississippi's next policy option is expansion, which is defined as expanding Medicaid eligibility to low-income adults that are at or below 138% of the FPL. Expansion criteria is divided into four broad categories: adoption through the standard legislative process, adoption through the standard legislative process with a Section 1115 Waiver to modify the traditional expansion program, adoption through executive action, and adoption through a ballot initiative (Antonisse & Rudowitz, 2019). The following analysis will give an in-depth view into which policy options are most feasible for Mississippi if policymakers or the electorate choose to adopt expansion.

Adoption Through the Standard Legislative Process

So far, 22 states have chosen to traditionally expand Medicaid through the standard legislative process. States that have chosen this method are primarily concentrated on the West Coast and the American Northeast. Most of these states are Democratic strongholds; states like California, Oregon, and New York are governed by Democratic juggernauts Jerry Brown, Kate Brown, and Andrew Cuomo, respectively. There are exceptions to this trend: traditionally conservative states like North Dakota and West Virginia expanded Medicaid through the standard legislative process.

Lawmakers in traditionally liberal states have had overwhelming political capital in expanding Medicaid through the standard legislative process. For instance, polling suggests that Democratic voters are overwhelmingly supportive of expansion. One poll suggests that 91% of Democrats support giving “states the option of expanding their existing Medicaid program to cover more low-income, uninsured adults” (Brodie, Kirzinger, & Wu, 2018, Table 2). With states that have party registration, there is a clear trend that states with Democratic pluralities are likely to adopt expansion. Of the 22 states that have expanded Medicaid through the standard legislation process, 15 have party registration. Of those 15 states, nine have Democratic registered voter pluralities; five have Independent registered voter pluralities, but they all have more Democratic registered voters than Republican registered voters; and none of the states have a plurality of registered Republican voters. (Cook, 2018).

This data suggest that expansion through the standard legislation process is very unlikely for Mississippi. Since there is no party registration in Mississippi, it is impossible to assume the exact number of Republican voters. Voting trends, however, suggest that Mississippians are overwhelmingly Republican. The last time Mississippi elected a Democratic governor was in 2000 with the election of Ronnie Musgrove, who only served one four year term. The last Democratic Lieutenant Governor was Amy Tuck who switched to the Republican Party only two years into her first term. The Mississippi Senate and the Mississippi House of Representatives both have had Republican majorities since 2011 and 2012, respectively. The literature suggests that on the state level, Republicans are vociferously opposed to expansion. There are only few instances where Republican leadership has produced Medicaid expansion through the standard legislation process, like Governor Christie in New Jersey.

Adoption Through the Standard Legislative Process With a Section 1115 Waiver

Some states have opted to expand through the standard legislative process with a Section 1115 waiver. Section 1115 is a provision under the Social Security Act that gives the United States Secretary of Health and Human Services authority to allow states “to test and evaluate innovations in certain state-administered public programs, including Medicaid” (Gunsalus, Rosenbaum, Rothenberg, & Schmucker, 2016, p. 1). States that expand Medicaid through Section 1115 waivers give researchers important data to examine which policies are effective and ineffective in expanding positive health and economic outcomes among low-income adults.

Eight states have chosen this method, including Arizona, Arkansas, Indiana, Iowa, Kentucky, Michigan, Montana, and New Hampshire. Of these eight states, three have

Independent registered voter pluralities, but they all have more than Republican registered voters than Democratic registered voters. One has a Democratic registered voter plurality, and three have no voter registration. Of the states with no voter registration, two of them are solidly Republican, including Indiana and Montana. Indiana voters have not elected a Democratic governor since 1996. The Indiana Senate has been dominated by Republicans for forty years straight, and the Indiana House of Representatives have been dominated by Republicans since 2011. Montana's current governor is Democrat Steve Bullock, and his predecessor was also a Democrat; however, Montana is solidly Republican in federal elections. Montana has voted for the Republican ticket for President since 1996.

Of the standard legislative processes, the Section 1115 waiver method is the most likely to succeed in Mississippi. The changes to the Section 1115 waiver program under the ACA were primarily formed as a pragmatic solution to non-traditionally expand Medicaid. The United States has a broad political spectrum, and it is inaccurate to assume that all states would willingly accept traditional expansion due to core ideological differences, especially after the *National Federation of Independent Business v. Sebelius* decision in 2012.

As the previous analysis shows, Section 1115 waivers for expansion are popular in traditionally Republican states. There is virtually no chance that traditional Medicaid expansion would pass through the standard legislative process in Mississippi. There is simply no proof that it is viable, unless Mississippi became an outlier. Even Arizona, which initially expanded through the traditional method, reversed its policy and

“subsequently obtained waiver authority to alter the terms of that expansion in ways not otherwise permitted under existing law” (Hinton, Musumeci, & Rudowitz, 2017, p. 2).

There is a consistent theme among the expansion policies instituted through the Section 1115 waivers: “increasing beneficiary financial responsibility, not only at the point of care through increased cost-sharing for certain services but also at the point at which coverage is obtained by requiring people to pay an ongoing, monthly premium or enrollment fee for their coverage” (Gunsalus et al., 2017, p.1). Despite this common goal, each Section 1115 waiver is unique. The following section will provide brief overviews of each state that has expanded through Section 1115 waivers. These overviews can offer lawmakers a glimpse into other state’s experimentations with the program, seeing what is effective and what is not. All of the following data regarding these different policies originated from the Kaiser Family Foundation. The end of the next section will offer recommendations on which provisions Mississippi could feasibly adopt.

Arizona.

The Section 1115 waiver submitted by Arizona changed the traditional expansion the state initially accepted by Governor Brewer. It transferred the expansion population, which is 100-138% of the FPL, from the traditional Medicaid program to the new program, which imposes premiums that are 2% of income or \$25 a month, whichever is less; imposes co-payments that can reach 3% of income paid monthly into health savings accounts; and creates a program centered on promoting healthy behaviors. Participation in this program is optional for American Indians and Alaska Natives, along with people that have serious mental illness and those who are medically frail. The co-payment plan offers set prices for certain medical services. For example, co-payments for opioid

prescriptions are \$4. Co-payments for non-emergency use of the emergency room are \$8. If premiums are not paid after a two-month grace period, beneficiaries above 100% of the FPL may be disenrolled. Re-enrollment is relatively easy; they may enroll at anytime without paying past due amounts.

Arkansas.

The primary feature in Arkansas' Section 1115 waiver is the use of Medicaid funds to pay for Marketplace Qualified Health Plans (QHP) or employer sponsored health insurance (ESI) premiums for all newly eligible adults, which is limited at 138% of the FPL. A QHP is "an insurance plan that's certified by the Health Insurance Marketplace [that] provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements under the [ACA]" (Healthcare.gov, 2019). ESI refers to health insurance plans that employers offer their employees as part of an employment package.

An extension of the waiver has eliminated the health savings account program similar to one operated by Arizona. Along with this change, the waiver extension established monthly premiums to a limit of 2% of household income for newly enrolled beneficiaries from 100-138% of the FPL. The coverage group in this waiver is newly eligible parents ages 19-64 between 17%-138% of the FPL; newly eligible adults ages 19-64 without dependent children qualify between 0-138% of the FPL. One section of the waiver specifically authorizes the rules regarding the program's premiums and cost-sharing measures. With regard to the QHPs, the state pays the monthly premiums; with the ESIs, employers are required to pay 25% of the overall cost. Cost-sharing does not

exist for beneficiaries at or below 100% because the beneficiaries simply cannot afford to share the cost.

Indiana.

Indiana has used its Section 1115 waiver to expand coverage to most newly eligible adults, who are defined as adults ages 19-64 with incomes 0-138% of the FPL, by requiring them to pay monthly premiums to the Personal Wellness and Responsibility (POWER) health account. Adults that pay premiums are eligible for the Healthy Indiana Plan (HIP) Plus, which is an expanded benefit package that requires co-payments only for non-emergency use of the emergency room. Eligible adults with incomes from 101-138% of the FPL will automatically be disenrolled from coverage and barred from re-enrolling for six months if they fail to pay premiums after a 60-day grace period. Those at or below 100% who fail to pay premiums after the 60-day grace period will be downgraded to HIP Basic, which is a healthcare package with more limited benefits.

HIP Plus and HIP Basic are known as Alternative Benefit Plans (ABP), which are healthcare plans outlined in the ACA that must cover ten essential health benefits (EHB). The ten benefits are as follows: ambulatory patient services (outpatient services); emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services (those that help patients acquire, maintain or improve skills necessary for daily functioning) and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. HIP Plus includes the ACA's essential health benefits and covers more services than HIP Basic. HIP Basic is an ABP that includes these same

benefits, just with fewer covered services such as no vision or dental care and less generous prescription drug coverage than HIP Plus.

Iowa.

Iowa's Section 1115 waiver program covers newly eligible adults to 138% of the FPL. Premiums are the primary feature, but they are deferred. After the first year of enrollment, beneficiaries from 50-100% have to pay \$5 a month premiums; beneficiaries from 101-138% have to pay \$10 a month after the first year. Beneficiaries from 101-138% of the FPL have a 90-day grace period to pay past-due premiums before disenrollment.

One unique feature is financial incentives. Individuals who have completed health risk assessment and a wellness exam can complete the specified preventive health-related activities, such as receiving specialized care like dental exams or halting unhealthy behavior like smoking cessation, to earn financial rewards. Another feature is bureaucratic discretion in waiving premiums. For example, the state's Section 1115 waiver allows the state to waive premiums for beneficiaries that self-attest to financial hardship.

Kentucky.

Kentucky has many of the same features as the other Section 1115 waiver programs, such as premiums and grace periods for non-payment. One unique feature, however, is a work requirement for "able-bodied" working age adults which is fulfillable in multiple ways, such as volunteer work, employment, job search, job training, education, or caring for a non-dependent relative or person with a disabling chronic condition. This work requirement must be verified within three months of enrollment.

The work activity must be at least 20 hours per week. Beneficiaries self-attest their work hours. If there is verifiable proof that beneficiaries are making false claims regarding their work activity, then they will be automatically disenrolled and ineligible for re-enrollment for six months.

Michigan.

Michigan's program covers childless adults ages 19 to 64 from 0-138% of the FPL. It requires copayments from all beneficiaries, and the monthly amount is calculated based on the average copayments for healthcare services throughout the previous six months. Premiums are paid into health savings accounts and are equal to 2% of monthly income. Starting in April 2018, medically frail beneficiaries that are above 100% of the FPL are eligible for two options, which include continued coverage through Medicaid or Marketplace QHP coverage with premium assistance and cost-sharing subsidies.

Montana.

Montana's program covers roughly 70,000 adults through a managed fee for service (FFS) Third Party Administrator (TPA). It requires premiums that are limited to 2% of income for beneficiaries from 51-138% of the FPL. Beneficiaries that are from 101-138% of the FPL that fail to pay their premiums will be dis-enrolled from the program after a 90-day grace period. To re-enroll, previous beneficiaries either pay the premiums or the state's Department of Revenue assess the premium debt against income tax refunds.

New Hampshire.

New Hampshire's program mimics Arizona's use of Medicaid expansion to pay for Marketplace QHP premiums for all newly eligible adults. Coverage groups are

divided into parents and childless adults, and parents are divided into working and non-working. Non-working parents with incomes between 38-138% of the FPL and working parents between 47-138% are eligible. Childless adults ages 19-64 between 0-138% of the FPL are also eligible. Premiums are paid by the state; beneficiaries are not required to pay any of the premium costs. Beneficiaries below 100% of the FPL have no co-payments; beneficiaries from 100-138% of the FPL are required to make co-payments at state plan amounts.

Adoption through Executive Action

Four states, Alaska, Kentucky, Louisiana, and Maine, have current expansion programs that were initiated through executive action. In 2015, then-Governor of Alaska Bill Walker, an Independent, expanded through executive order, “relying on a state law that requires Alaska to cover all groups that states must cover under federal Medicaid law, usually referred to as mandatory coverage groups” (Solomon, 2017, para. 4). In a press conference given at the Anchorage Neighborhood Health Center, Governor Walker touted expansion’s success by stating that it has given health insurance coverage to nearly 40,000 Alaskans (Mackintosh, 2018).

Governor Walker’s decision sparked opposition. In 2015, Alaska’s Senate filed an unsuccessful lawsuit against the Governor’s executive action, citing that he overstepped the legislative process (Mackintosh, 2018). Then-Senator Mike Dunleavy, who is Alaska’s current Republican governor, was one of the proponents of this lawsuit. During his gubernatorial campaign, Governor Dunleavy supported “helping more Alaskans find health insurance without government assistance” (Mackintosh, 2018, para. 8).

In Kentucky, then-Governor Steve Beshear, a Democrat, announced his intention to unilaterally accept Medicaid in a news conference in the state capitol through executive action. An emotional Governor Beshear boldly claimed that expansion would be “the single most important decision in our lifetime” (Beshear, 2013). Before his decision, Governor Beshear invited PricewaterhouseCoopers and the University of Louisville Urban Studies Institute to examine the economic impact of expansion. These entities concluded that Kentucky could simply not afford to deny expansion. They concluded that over eight years, \$15 billion would be infused into Kentucky’s economy while simultaneously creating roughly 17,000 jobs.

In Louisiana, Democratic Governor John Bel Edwards signed an executive order starting the process of expanding Medicaid. For years, then-Governor Bobby Jindal and his Republican legislative majority opposed expansion, arguing that expansion “provided inadequate care and expanding the government program eventually would saddle Louisiana taxpayers with unsustainable costs” (Ballard, 2016, para. 10). Governor Edwards’ executive order directed the Louisiana Department of Health and Hospitals (DHH) to create amendments to expand coverage to adults who are at or below 138% of the FPL with an effective date of no later than July 1, 2016, which was less than six months after the order was signed.

Newly elected Democratic Governor Janet Mills of Maine was in a similar situation by signing an executive order expanding Medicaid. She signed Executive Order 1 the morning after her inauguration, which expanded Medicaid eligibility to more than 70,000 Mainers (Lawlor, 2019). This policy change was in stark contrast to previous Governor Paul LePage. In November 2017, Maine voters approved Medicaid expansion

by a 59-41% margin, but Governor LePage refused to implement it. He stifled until Governor Mills gained power.

Referendum

This method was previously discussed by the researcher. Voters in Idaho, Montana, Nebraska, and Utah voted on Medicaid expansion. Montana's voters were approached with a slightly different question: whether the state should continue participation in the program. As noted earlier, Montana expanded its Medicaid program in 2015 to nearly 129,000 low-income adults, "but Montana's Legislature only funded the program for four years" (Kliff, 2018, para. 12). The referendum failed.

The likelihood for implementing expansion through the referendum method is low. This is not because Mississippians are not in favor: in January 2019, one credible poll found that more than 60% of Mississippians were in favor of expansion, a wide margin of support for any policy proposal (Millsaps College, 2019). The barrier is the "initiative process" itself. Mississippi has an indirect initiative system, meaning proposals go to the legislature before voters. This process is not technically a referendum, either. This initiative process requires approval by state legislators, and adopted initiatives amend the constitution, which is no small feat in any state. Since Mississippi's initiative process has been regarded as one of the most difficult in the country, it is very unlikely that Medicaid expansion will be adopted through the initiative process and is not recommended as a viable policy option.

Final Recommendations

Of the available policy options regarding expansion, adoption by the standard legislative process with a Section 1115 Waiver would be a feasible policy option for

Medicaid expansion in Mississippi. First, the states that have adopted expansion through the traditional standard legislative process are primarily governed by Democratic lawmakers, which is the exact opposite of the political climate in Mississippi. Results from recent presidential elections tell the same story. States that consistently vote for Democratic presidential candidates have a clear trend of expanding Medicaid, while states that consistently vote for Republican presidential candidates have a clear trend of not expanding Medicaid. Since 2000, every state in New England has voted for the Democratic presidential candidate except for New Hampshire in 2000, and each of those states have expanded through the traditional standard legislative process. Contrarily, the Deep South, including Mississippi, Alabama, Tennessee, and Georgia, has voted for the Republican presidential candidate each election since 2000.

Second, Mississippi's lawmakers, especially in the executive branch, are opposed to expansion, especially through the traditional standard legislative process. In a quote from Governor Bryant's spokesman Knox Graham, he expressed the following sentiment: "Governor Bryant doesn't have Medicaid expansion on his legislative agenda, and he doesn't foresee that occurring this year" (Graham, 2019, para. 14). Two-term Lieutenant Governor Tate Reeves, who is running for Mississippi's governorship in 2019 and considered the "heir-apparent" to Governor Bryant, is adamantly opposed to expansion. He consistently refers to expansion as "Obamacare expansion" in a clear attempt to conflate President Obama with government spending. In a quote, he explained that he is against "Obamacare expansion in Mississippi because it is not in the best interest of taxpayers" (Reeves, 2019, para. 18). The other gubernatorial Republican candidates, state Senator Robert Foster and Former Chief Justice of the Mississippi

Supreme Court Bill Waller, Jr., have also expressed their restraint in implementing expansion (Bologna, 2019). The Democratic frontrunner for governor, Mississippi's current Attorney General Jim Hood, has touted Medicaid expansion as a main campaign promise. In his announcement speech for governor on the steps of the Chickasaw County courthouse, he floated expanding Medicaid, saying "we shouldn't leave hundreds of millions of federal dollars on the table" (Hood, 2018, para. 6).

Third, pressure from the next Lieutenant Governor may influence Mississippi's next governor's decision in expanding Medicaid through a Section 1115 waiver. The Republican and Democratic front runners in the Lieutenant Governor's race are current Mississippi Secretary of State Delbert Hosemann and current state Representative Jay Hughes, respectively, and they have both expressed support for some method of expansion. Secretary Hosemann has asserted that the only method of expansion he would support would be through a Section 1115 waiver, stating that he would support a plan "similar to what Indiana and Arkansas did" (Bologna, 2019, para. 23). Representative Hughes is supportive of expanding Medicaid in "whatever manner increases healthy outcomes and the thousands of medical jobs we left on the table," insinuating that he is pragmatically in support of expansion, either through the traditional standard legislation method or the Section 1115 method.

Chapter 6: Conclusion

In late March of 2019, the DOJ announced their intention not to defend the ACA in the federal judiciary whenever it sent a letter to the United States Court of Appeals for the Fifth District, emphasizing to uphold the judgement Judge O'Connor issued in Federal District Court in December. Exasperated by the Administration's decision, Congressional Republicans rebuked this decision. Senator Mitch McConnell, the current Senate Majority Leader, expressed his concerns to President Trump in several private conversations, telling the President that he believed Democrats would own Republicans on this decision (Pear & Haberman, 2019). In response, President Trump reversed his position, stating that he would only address the issue after the 2020 elections, when he predicts that Republicans will regain control of the House of Representatives and keep control of the Senate, along with himself winning reelection.

This reversal suggests that Republican politicians are apprehensive to campaign against the ACA. As discussed in Chapter 2, the ACA has gotten more popular as President Trump's term has progressed. Medicaid expansion has become increasingly popular, even in non-expansion states. According to one poll, 59% those living in non-expansion states, which are overwhelmingly conservative, want their states to expand Medicaid. Of the provisions in the ACA, Medicaid expansion is one of the most popular.

This upward trend in approval in non-expansion states is likely linked to dissatisfaction with non-expansion state's residents' generally poor health and economic outcomes compared to Americans writ large, especially in Mississippi. In general, Mississippians are unhealthier than the typical American, especially outside the Deep

South. Data from the CDC suggest that Mississippians overwhelmingly lead in mortality from prevalent chronic diseases like CVD and diabetes. As discussed in Chapter 4, low-income adults living below 138% of the FPL have little disposable income to spend on important healthcare expenses.

If Medicaid expansion were implemented in Mississippi, thousands of Mississippians would receive health insurance coverage, nearly eliminating out-of-pocket costs. The grim reality for those potentially eligible low-income adults is that Mississippi's lawmakers are generally opposed to expansion, unless it is through a Section 1115 waiver. This waiver system has been implemented in several states, and certain provisions that have been effective in those states would likely be successful in Mississippi as well.

For example, Arkansas and Mississippi are economically and demographically similar. Both have roughly the same population: Mississippi has roughly 2.9 million, while Arkansas has roughly 3 million. They have virtually the exact same median household income, which are both significantly lower than the American average. Both have high poverty rates. Despite these similarities, Arkansas' uninsured rate is much better than Mississippi's. Arkansas' is 9.3%, while Mississippi's is 14.2% (United States Census Bureau, 2017). In 2010, Arkansas' uninsured rate was nearly 16% and was trending upward, but the trend significantly reversed after expansion.

Arkansas and Mississippi are also politically similar. Both have Republican pluralities in their respective Executive and Legislative branches. This indicates that Mississippi could have a politically feasible plan to expand Medicaid through a Section 1115 waiver. Certain features, like the state government's purchase of QHP and premium

contributions by eligible adults, are market-based approaches to decrease the uninsured rate, and these conservative approaches would likely be politically popular.

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