

POLICY FOCUS

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Medicaid's COVID-19 Challenges

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HIGHLIGHT

Across our society and government institutions, Americans understandably struggled to navigate the COVID-19 pandemic. Some mitigation strategies were effective and helpful. Others—even those that may have been initially warranted—stayed in place far too long and have been abused. This is the case with the Department of Health and Human Services Determination of a Public Health Emergency and a related continuous enrollment requirement for the Medicaid program.

INTRODUCTION

If there's still a public health emergency going on, Americans are not acting like it: Airport passenger traffic is back up to near **pre-pandemic levels** and fliers aren't even required to wear masks. Kids everywhere are **back in school**—although this should have been the first, rather than the last, priority. And the healthcare system is **no longer strained** by waves of COVID-19 patients, thanks to a variety of factors related to the virus, immunity, and treatments. Even President Joe Biden believes the pandemic is over, as he stated in September 2022.

It's time for the Department of Health and Human Services (HHS) to recognize this and allow the [public health emergency determination to expire](#). Most recently, just weeks before a national election, HHS renewed the public health emergency in mid-October for 90 more days. The end of this determination will—among other things—allow states to remove ineligible enrollees from the Medicaid program, which ballooned during the pandemic. Overloading Medicaid with too many enrollees takes resources away from those who need them most, keeps too many people on inferior public coverage when they could otherwise be on private insurance plans, costs taxpayers in the form of increased social spending, and moves our public policy closer to government-controlled health care and farther from a vibrant, competitive private marketplace.

Medicaid was originally designed to protect the most vulnerable Americans, including indigent mothers, children, the elderly, and people with disabilities, from going without health insurance. But the program has experienced various expansions. During the pandemic, enrollment grew by more than 17 million people, or 25 percent, to a total of [more than 89 million](#). This means that today, Medicaid insures more than one in four Americans. Clearly, some policymakers see the expansion of Medicaid as a good thing, and as a path to universal government health insurance. But this path, paved with good intentions, will not lead to good outcomes.

MEDICAID HISTORY AND BACKGROUND

In 1965, Medicaid was established alongside Medicare, the federal health insurance program for people aged 65 and older. In contrast to Medicare, which is funded in part by a payroll

tax and facilitated by the federal government, Medicaid is a safety-net program for people of all ages, funded by federal and state tax dollars, and its implementation varies from state to state. The similar-sounding names of these two programs often result in confusion.

Medicare

- Started in 1965
- No premium for basic Medicare (but can pay/opt into additional parts)
- For people 65 and older
- Operated by federal govt
- Funded in part by payroll tax

Medicaid

- Started in 1965
- No premium
- For low-income individuals of all ages
- Operated by the states, according to federal rules
- Funded by federal govt and states

From 1965 until 2013, states determined Medicaid eligibility, within some basic federal guidelines. Many states limited Medicaid to only certain populations, such as low-income pregnant women, children, the elderly, and people with disabilities. Traditionally, childless, working-age, able-bodied adults were not eligible for Medicaid. But some states offered it to everyone under a certain income threshold, usually a function of the federal poverty line.

THE AFFORDABLE CARE ACT MEDICAID EXPANSION

[This all changed with the Affordable Care Act](#), or ObamaCare, which initially required that states expand Medicaid to one federal eligibility standard or forfeit all Medicaid funding. The Supreme Court struck this down, however, and held that Medicaid expansion was optional: States could choose to accept generous additional funding to expand Medicaid to all adults up to 138 percent of the federal poverty line. Or they could choose

not to participate in the expansion and keep their pre-existing Medicaid funding for the “traditional” Medicaid population in their state.

To date, **39 states** have opted into the ACA’s Medicaid expansion. As a result, **21 million** people have been added to Medicaid coverage. Medicaid coverage growth **dwarfs other coverage growth** related to the Affordable Care Act’s other provisions that expanded private insurance (such as the establishment of exchanges, or “marketplaces,” to buy subsidized plans or mandates to cover people with pre-existing conditions or young adults on their parents’ plans **until age 26**).

The Medicaid expansion in the ACA has been studied in depth from a variety of angles. To summarize, the expansion:

- Resulted in many more people enrolling than expected (**as many as 50 percent more**).
- Expanded public health coverage, but **decreased** private health insurance coverage.
- Was associated with mixed results related to health access and outcomes. For example, some studies have shown that Medicaid expansion coverage was associated with higher rates of **primary care use**, but other studies indicate no evidence of changes to **general health status** due to the Medicaid expansion.
- Reduced the chances that low-income adults in expansion states had **unmet health needs** or faced financial stress associated with **medical bills**.
- Was associated with lower premiums for **ACA exchange plans** (because Medicaid expansion resulted in a lower-risk pool of exchange consumers).

- Was associated with longer **wait times** for care, increased **emergency department use**, and more **difficulty finding a physician**.
- Was not associated with differences in **Medicaid acceptance rates** among health providers, with one exception: OBGYNs in expansion states accepted Medicaid *less* often than OBGYNs in non-expansion states.
- Was not associated with any increase in longevity, as average life expectancy only decreased between 2013 and 2019 (and has further decreased since 2019, with COVID-19’s impact). In fact, mortality trends were worse, on average, **in expansion states**.
- Cost far more than initially projected (**as much as 50 percent more**).
- Boosted **hospital profits** in expansion states.
- Was associated with **lower labor force participation**.

In general, the consensus about Medicaid coverage is that, while it offers financial security and other benefits compared to being *uninsured*, it is inferior to private health insurance, which is typically accepted by a wider network of providers and therefore offers better access to care. This makes it particularly concerning that Medicaid may be “**crowding out**” private coverage.

More providers are willing to accept private insurance plans, and even Medicare, because these plans reimburse more for their treatments and services. On average, private insurance pays nearly twice (**189 percent**) as much money for inpatient services and even more than twice (**264 percent**) as much for outpatient services compared to Medicare; Medicaid pays even less than Medicare for both inpatient and outpatient services. Medicaid on average pays **72 percent** of what Medicare pays.

These low reimbursement rates—as well as **administrative problems** that often result in disputed and denied claims from healthcare providers—make it less attractive for providers to participate in Medicaid. To a lesser degree, the same is true for Medicare.

Policymakers have experimented with increasing the reimbursement rates in Medicaid, in hopes of enticing more providers into the program and improving access to care. Providers consistently cite Medicaid's low payment as their primary reason for not participating in the program. Higher payments **are associated** with higher provider participation in Medicaid, but of course one tradeoff is that higher Medicaid fees make the program more costly to taxpayers.

such waivers approved (and imposed work/training requirements) and nine more states applied for waivers, but either withdrew them or had them denied.

The work requirements—known as “community engagement” requirements—weren't just requirements to have jobs. They could also be fulfilled by studying or caregiving full-time, searching for a job, or participating in a job training program. And the requirements didn't apply to people with disabilities or those who were pregnant, elderly, or otherwise medically frail.

The goal of these requirements was to encourage labor force participation among Medicaid recipients. Critics said

The kind of budget slashing required to achieve “universal coverage” would create true healthcare shortages, requiring significant hospital closures and life-threatening delays and denials of care. Quality care, not coverage, should be the goal.

This reimbursement issue poses particular problems for proposals like “Medicare for All,” which would necessitate a **40 percent reduction** in average payments to hospitals and providers. This kind of budget slashing might make it possible for the United States to claim “universal coverage,” but would create true healthcare shortages, requiring significant hospital closures and life-threatening delays and denials of care. Quality care, not “coverage,” should be the goal.

WORK REQUIREMENTS AND MEDICAID

In January 2018, the Trump administration invited states to apply for Section 1115 waivers, which could be used to impose work, education, and training requirements for Medicaid eligibility. In total, **13 states** had

the requirements were not helpful since most Medicaid recipients already work or otherwise would be exempt. But proponents of work requirements point out that on average, non-disabled men on Medicaid work only **13 hours per week**. Women work 12. Work requirements would encourage many Medicaid recipients to work more hours per week, increasing their wages and thereby their living standards.

Starting in February 2021, the Biden administration worked to undo the previous administration's decisions on work requirements in Medicaid. No state is currently allowed to impose work restrictions for Medicaid eligibility. This could change with future administrations.

Policymakers should consider ways to strengthen the Medicaid program by

restricting eligibility to only those with the greatest need, and otherwise transitioning other able-bodied adults to private coverage. Work requirements for other social programs, although they impose additional administrative burdens, can fend off abuse and can increase **employment rates** in beneficiaries.

The welfare reforms of the 1990s were very successful in this regard, but work requirements—for a variety of reasons—have lost momentum in recent years and labor force participation among poor Americans has decreased.

The welfare reforms of the 1990s were **very successful** in this regard, but work requirements—for a variety of reasons—have lost momentum in recent years. At the same time, labor force participation among poor Americans has decreased. Encouraging work should still be a public policy goal because of the myriad benefits **to physical health, mental health, and long-term financial security** to workers.

THE COVID-19 PANDEMIC

Understandably, policymakers didn't want low-income Americans who depend on Medicaid to lose coverage in the midst of a true public health emergency. The Families First Coronavirus Response Act increased Medicaid funding for states on the condition that they did not disenroll any beneficiaries until the end of the HHS Determination of a Public Health Emergency. This is called a "continuous enrollment" requirement. Unsurprisingly, **enrollment in Medicaid ballooned**.

Since February 2020, more than **17.7 million** people have been added to Medicaid. This represents a 25 percent increase in enrollment. During the same time, enrollment in private health insurance **decreased**, as did

the number of Americans with no health insurance.

Medicaid advocates do not see increased Medicaid enrollment as a problem. Instead, they celebrate growth in Medicaid enrollment and see the program as one avenue to **universal coverage**. At the state level, some

progressive policymakers have even sought to open Medicaid enrollment up to everyone with Medicaid "buy-in" programs, effectively making the program a "public option."

This approach eschews Medicaid's original purpose as a safety-net program for marginalized populations. We should celebrate not adding people to Medicaid, but subtracting them, as long as they move out of the program into self sufficiency. This allows Medicaid to **better direct resources** to those who truly have no other better options.

Safety-net programs are most effective when they are targeted, temporary, and provide strong accountability and oversight safeguards. Otherwise, they can be abused. The extension of the COVID-19 Public Health Emergency Determination—seven times—has outlived its justification, and now seems to only be a means to reaching a progressive policy goal that would otherwise be subject to the legislative process, where expansions of social programs are scored for cost, debated, and enacted only with the consent of people's elected representatives. (Other pandemic-era changes to health policy, such as the **expansion of tele-health services**, are rightly being considered and debated as legislative proposals.)

One report estimates that about **13 percent** of present Medicaid enrollees could be kicked out of the program when the Public Health Emergency ends, representing about 14 million people. States report that **increased incomes** will be the primary reason for disenrollment. For these people, and others in Medicaid, we should look for better healthcare solutions, and enact those solutions through the appropriate process—not through emergency powers.

BETTER HEALTHCARE SAFETY-NET SOLUTIONS

One of Medicaid's advantages is that, as a joint federal-state program, states can innovate and experiment with eligibility requirements and coverage benefits that work best for their populations and the healthcare systems that serve them. Some states are indeed experimenting, although sometimes the federal government precludes this federalist process unnecessarily (as with work requirements).

Policymakers should work to preserve and strengthen Medicaid for those with the greatest need. At the same time, they should work to make private health insurance affordable and accessible to able-bodied working-age adults. This would maximize access to the best health care and benefit Medicaid beneficiaries and taxpayers alike. This should be our ultimate goal, pandemic in, pandemic out.

Minnesota and New York have “**basic health plans**” designed for the just-above-Medicaid demographic, and Oregon and Kentucky will soon join them. Massachusetts, Vermont, **and several other states** subsidize private health insurance for people with low incomes.

Arkansas expanded Medicaid in an **innovative way**, offering premium assistance to people in the expansion population and enrolling them in private plans rather than traditional Medicaid. This premium support model is

promising and deserves more support. Private health coverage is associated with **much better healthcare access and outcomes** than Medicaid.

But at the heart of the problem for many low-income Americans is the high cost of private health insurance. This is the challenge even for premium-support policies like the one in Arkansas.

Policymakers concerned with a lack of access to high-quality health insurance for low-income Americans should focus on combating the root causes of high health insurance premiums: a lack of competition in our nation's highly consolidated (and **worsening**) health insurance market, the costly and distortive **employer tax exclusion** for large group plans, and **expensive federal health insurance mandates**.

Ending the COVID-19 Public Health Emergency and the continuous enrollment

requirement for Medicaid presents a challenge, but also a great opportunity. Policymakers should work to preserve and strengthen Medicaid for those with the greatest need. At the same time, they should work to make private health insurance affordable and accessible to able-bodied working-age adults. This would maximize access to the best health care and benefit Medicaid beneficiaries and taxpayers alike. This should be our ultimate goal, pandemic in, pandemic out.

WHAT YOU CAN DO

Get Informed

Get Informed: Learn more about Medicaid. Visit:

- [Medicaid and CHIP Payment and Access Commission](#)
- [Foundation for Government Accountability](#)
- [Kaiser Family Foundation](#)

Talk to Your Friends

Help your friends and family understand these important issues. Share this information, tell them about what's going on and encourage them to join you in getting involved.

Become a Leader in the Community

Start an Independent Women's Network chapter group so you can get together with friends each month to talk about a political/policy issue (it will be fun!). Write a letter to the editor. Show up at local government meetings and make your opinions known. Go to rallies. Better yet, organize rallies! A few motivated people can change the world.

Remain Engaged Politically

Too many good citizens see election time as the only time they need to pay attention to politics. We need everyone to pay attention and hold elected officials accountable. Let your Representatives know your opinions. After all, they are supposed to work for you!

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Please visit us on our website iwf.org to get more information and consider making a donation to IWF.

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Independent Women's Forum (IWF) is dedicated to building support for free markets, limited government, and individual responsibility. IWF, a non-partisan, 501(c)(3) research and educational institution, seeks to combat the too-common presumption that women want and benefit from big government, and build awareness of the ways that women are better served by greater economic freedom. By aggressively seeking earned media, providing easy-to-read, timely publications and commentary, and reaching out to the public, we seek to cultivate support for these important principles and encourage women to join us in working to return the country to limited, Constitutional government.