Closing the Medicaid Coverage Gap: Preventing a Separate and Unequal Result

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I. Introduction

Among other aims, the architects of the Patient Protection and Affordable Care Act (ACA) of 2010 envisioned near-universal health coverage nationwide.[2] The law created a new Medicaid eligibility category for adults aged 19–64 with incomes at or below 133 percent of the federal poverty level (FPL) who are not pregnant, covered by Medicare, or otherwise entitled to Medicaid.[3] States receive an enhanced Federal Medical Assistance Participation (FMAP) rate for this Medicaid "expansion" population, capping states' contribution to 10 percent of the costs. In contrast, Congress designed the ACA's health insurance Marketplace (Marketplace), Qualified Health Plan (QHP) requirements, and associated advance premium tax credit and cost sharing structures to cover people with incomes at or above poverty. Two years later, in *National Federation of Independent Businesses v. Sebelius* (2012), the Supreme Court dramatically undercut the ACA's structure by enabling states to decide whether to take up Medicaid expansion.[4]

Today, thirty-nine states (including DC) have taken action to expand Medicaid.[5] In 2019, expansion covered over 12 million people.[6] A myriad of studies show that expansion strengthens access to health care and improves health outcomes for Black, Indigenous, and other people of color (BIPOC); lesbian, gay, bisexual, transgender, queer, and gender-nonconforming (LGBTQ-GNC) people; pregnant and postpartum people; and people with chronic health conditions or disabilities.[7] Unfortunately, policymakers in twelve states refuse to expand Medicaid—a discriminatory political choice intertwined with racism in policymaking.[8] The result is the Medicaid coverage gap: an estimated 4.4 million people with low incomes—nearly all of whom live in Southern states and a majority of whom are Black, Latinx, or other people of color—were uninsured because of non-expansion in 2020.[9] These are parents, people with disabilities or chronic health conditions, LGBTQ-GNC people, and workers with low incomes. They have been left behind for too long.

Congressional action to expand coverage for these individuals is an urgent moral, anti-racist, health equity, reproductive justice, and economic imperative. The Medicaid coverage gap contributes to racial injustices in public health crises such as the COVID-19 pandemic, our national Black and Indigenous maternal mortality epidemic, the Southern HIV epidemic, and more.[10] The American Rescue Plan (ARP) Act of 2021 offered holdout states substantial financial incentives to expand Medicaid. In addition to the ACA's 90 percent FMAP for the Medicaid expansion population after 2020, under the ARP Act, new expansion states would receive an additional 2 year, 5-percentage-point FMAP increase for their non-expansion populations.[11] Expanding Medicaid under the ARP would more than pay for itself: it could increase non-expansion state economies by a total of $350 billion from 2022 to 2025, and create more than one million jobs nationwide.[12] The continued inaction of non-expansion states is fueling momentum for policy proposals to close the Medicaid coverage gap through federal action, particularly by establishing a federally administered Medicaid program or fully subsidizing Marketplace coverage in lieu of Medicaid coverage.[13]

This paper provides foundational principles for equitably solving the Medicaid coverage gap. It addresses pressing questions about proposals, including:

- how and to what extent do they ensure access to Medicaid's vital comprehensive benefit, affordability, enrollment, and due process and consumer protections, lest they create a separate and unequal system of coverage for Black, Latinx, and other people of color in the South?
- how could they affect the stability of the Medicaid entitlement nationwide?
- how could they affect federal spending?

The principles aim to empower federal policymakers and advocates with a framework for developing, evaluating, and responding to proposals, and ensuring an equitable solution.

II. Ensuring Access to Medicaid's Vital Protections

Our country is well-versed in sustained imbalances in the allocation of power and resources, from voting rights to health care access, which are rooted in systems of oppression such as racism and gender-based discrimination. Together, these imbalances manifest in vast health inequities and social determinants thereof. People with low incomes, particularly BIPOC, LGBTQ-GNC people, and people with disabilities, often lack health insurance and experience urgent, persistent, and complex health care conditions.[14] They are more likely than people with higher incomes to have a substantial mix of chronic, behavioral, or acute health conditions.[15] For example, the early Medicaid expansion population in urban Minnesota experienced high rates of homelessness, substance use, and behavioral health conditions.

Over 25 percent experienced two or more of these challenges and 10 percent experienced all three.[16] Thirty-seven percent of enrollees were diagnosed with anxiety, mood, or schizophrenic disorders, and more than 25 percent were diagnosed with substance use disorders.[17] In addition, many people with disabilities who do not receive Social Security Income (SSI) (a pathway to Medicaid eligibility in most states) become eligible for Medicaid through Medicaid expansion. In 2018, over half of nonelderly adults with disabilities did not receive federal SSI.[18] Moreover, a significant portion of the expansion population has chronic health conditions. For example, in Ohio, over one-quarter (27 percent) of expansion enrollees had at least one chronic health condition.[19]

Unlike private health insurance, Medicaid provides a range of benefit, enrollment, affordability, and due process protections specially designed to meet the expansion population's complex needs.[20] These protections are critical to the prevention, early diagnosis, and treatment of health conditions such as diabetes and HIV.[21] **Any federal coverage gap solution must guarantee access to Medicaid's robust protections as the ACA intended. Otherwise, it could enshrine in federal law a separate and unequal system of health coverage for millions of Black, Latinx, and other people of color in the South, furthering structural racism in U.S. health policy**.

A. Comprehensive benefit protections

Comprehensive benefits are a defining component of the Medicaid entitlement. Solving the Medicaid coverage gap solution means ensuring access. States that expand Medicaid must provide an Alternative Benefit Plan (ABP) to their expansion population.[22] Although states can choose whether to align Medicaid expansion ABPs with the state's existing Medicaid State plan benefits or build standalone benefits packages based on a Medicaid benchmark (such as a public employee or commercial market plan), they have overwhelmingly chosen the former.[23] This trend reflects numerous advantages to states and enrollees, such as ensuring coverage of comprehensive benefits, minimizing churn and disruption for people who move between eligibility categories, and reducing administrative burden.[24] Of the thirty-seven states (including the District of Columbia) that had expanded Medicaid as of August 6, 2018, twenty-five (78 percent) elected to align ABP benefits with traditional Medicaid benefits under the State plan.[25] The ACA also requires that the remainder provide specified "exempt" populations, such as individuals who qualify as "medically frail," the choice of whether to enroll in the state's approved ABP or a benefit package equivalent to State plan benefits.[26] Large portions of Medicaid expansion populations may be entitled to full State plan benefits through such an exemption. For example, in 2018, 24 percent of the expansion population in Indiana (an expansion state that did not align its ABP with its State plan) identified as medically frail.[27]

State plans cover a variety of services that address complex health needs and are not traditionally covered by private health plans. There are some 30 mandatory and optional categories of services for which states can receive federal matching funds. States have flexibility in which services they cover, but must ensure that each service they cover is "sufficient in amount, duration, and scope to reasonably achieve its purpose," and that those standards are consistent with the objectives of the Medicaid Act.[28] Moreover, they cannot "arbitrarily deny or reduce the amount, duration or scope of a required service . . . to an otherwise eligible solely because of diagnosis, type of illness or condition."[29]

Mandatory services provide a mix of primary and specialty care tailored to the health needs of people with low incomes.[30] For example, state plans must cover home health services, nursing facility services for enrollees 21 or over, rural health clinic services, Federally-Qualified Health Center (FQHC) services, and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), a comprehensive benefit for enrollees under 21.[31] They must also provide non-emergency medical transportation (NEMT), addressing a critical determinant of health care access that is often out of reach for underserved people with low incomes.[32] Additionally, State plans cover a number of optional services including service delivery reforms that strengthen behavioral care, chronic health condition management, and primary care integration (*e.g.*, Patient Centered Medical Homes, Medicaid Health Homes, Assertive Community Treatment, and supportive housing services), dental services, and personal care services.[33]

Regardless of whether or not states align their Medicaid expansion ABPs with their State plans, they must cover all of the ACA's Essential Health Benefits (EHB) for the Marketplace **plus** additional Medicaid requirements.[34] For example, non-aligned expansion ABPs must cover NEMT, EPSDT, family planning services and supplies, parity in physical and behavioral health services, and ensure that the expansion population has access to, through coverage or otherwise, services at FQHCs, rural health clinics, and associated ambulatory services.[35] For most enrollees, Medicaid offers a more comprehensive range of benefits than the Marketplace. These comprehensive benefits are particularly important for the many people with disabilities or living with or at risk of chronic health conditions in the expansion population.

If Congress establishes a federally administered Medicaid program to close the coverage gap, it must ensure that the program covers the full scope of mandatory and "gold standard" optional Medicaid services (*e.g.*, Assertive Community Treatment, dental, vision, medication-assisted treatment). The Department of Health and Human Services (HHS) can leverage generations of experience running Medicare, a federal health insurance program that provides acute, primary, and prescription drug coverage for aging adults and people with disabilities.[36] It can also build on its history of financing community-based health care providers who provide comprehensive care management, cross-sector care coordination, and other health

services (*e.g.*, Federally Qualified Health Centers).[37] A federally administered Medicaid program could build on HHS' collective experience and existing relationships to cover and facilitate access to an appropriate range of benefits. It could also partner with Medicaid managed care plans, which increasingly incorporate whole-person care models to address complex health and health-related social needs.[38] Ultimately, it may be able to align with current Medicaid benefit protections more fully than a Marketplace approach.

If Congress instead addresses the Medicaid coverage gap through the Marketplace, it must require that expansion population QHPs cover both EHBs and State plan benefits. Enrollees cannot be left with less coverage than they would in Medicaid. Private Marketplace plans do not traditionally cover Medicaid's highly distinctive benefits, such as care coordination models that integrate physical and behavioral health, social, and public health services.

Further, a Marketplace-based solution should avoid wrapped-coverage arrangements, which undermine access to care. Health care reform experimentation has illustrated that having multiple forms of distinct health coverage is a risk factor for fragmented and poorly coordinated care. For example, "premium assistance" models that "wrap" Medicaid coverage around the Marketplace's limitations have been ineffective. Instead of directly covering health services or contracting with a managed care company to do so, states testing this approach pay QHPs premiums and cost sharing reductions to provide health services to non-exempt members of the expansion population.[39] When QHPs participating in these models do not include or fully cover services that State Medicaid programs must cover under federal law, states must step in to provide coverage. In practice, they struggle to implement this "wrapped" coverage approach effectively. This is much to the detriment of enrollees, who are left with a confusing patchwork of coverage for various benefits. Enrollees and safety net providers alike struggle to understand and access services and reimbursement. A similar dynamic is so problematic for people dually eligible for Medicaid and Medicare that the ACA established a new coordination office within the U.S. Centers for Medicare and Medicaid Services (CMS) as well as a multi-state demonstration program to test payment and care integration models, which have had limited and mixed findings to date.[40] This dynamic could similarly arise in Marketplace-based approaches to closing the Medicaid coverage gap if Marketplace QHPs do not cover services for which Medicaid requires coverage.

B. Affordability protections

Any coverage gap solution must ensure access to Medicaid's affordability protections. Decades of research document the relationship between cost-sharing and access to health care.[41] The literature overwhelmingly illustrates that heightened copayments hinder low-income

individuals' access to health services and prescription drugs, and premiums make it more difficult for them to enroll in and maintain coverage.[42]

Accordingly, the Medicaid Act sets out strict limitations on and extensive protections against cost-sharing. It generally prohibits premiums.[43] It allows only nominal copayments, often $4 maximum, for most routine services. Total cost-sharing and premiums cannot exceed 5 percent of aggregate household income. Crucially, cost-sharing is not enforceable for people under the poverty line: providers cannot deny services to enrollees with incomes below 100 percent of the FPL who cannot afford cost-sharing for a visit.[44] Regardless of income, several population groups and services are exempt from premiums and cost-sharing.[45] Providers can waive or reduce cost-sharing on a case-by-case basis. In addition, they are prohibited from "balance billing:" a practice of billing enrollees the difference between the provider's charge and Medicaid's payment for covered services.[46] Preserving these protections, such as unenforceable cost-sharing for people below the FPL who cannot afford to pay and prohibitions on balance billing, is critical to effectively closing the coverage gap.

Unfortunately, affordability is currently a significant barrier to Marketplace enrollment.[47] For example, premiums do not count toward the out-of-pocket limits and even when cost sharing reductions are applied, total cost sharing is higher than in Medicaid.[48] These affordability challenges would be even greater for the Medicaid expansion population, for whom even small cost increases could lead to large coverage failures. To ensure coverage gap enrollees retain the protections of Medicaid limits on cost-sharing, Congress would have to address issues including premiums, copayments, deductibles, and balance billing. Additionally, specific outreach and education would be essential to ensure that individuals browsing the Marketplace would be shown appropriate plans for coverage gap enrollees as they may not understand they could access a subsidized plan if they only see "regular" Marketplace plans designed for higher-income adults. Regular plans would be unaffordable due to premiums and may also provide inadequate coverage before deductibles are met.

C. Enrollment protections

Medicaid coverage gap proposals must preserve Medicaid's enrollment protections, **which ensure that eligible people who are navigating emergencies and societal barriers to health can swiftly enroll in and access critical and often lifesaving coverage**.[49] Medicaid provides individuals the right to apply for and enroll in coverage at any time. Its "point-in-time" eligibility system makes enrollment effective as of the date of application, even if it is not processed immediately.[50] Not only is there no waiting period before coverage begins, but Medicaid generally provides retroactive eligibility to cover health care expenses for the three months prior to the month of application, provided that an

applicant would have been eligible during that period.[51] Retroactive coverage ensures that people with low incomes who may encounter application delays due to hospitalization, institutionalization, or recovery can receive coverage for that care, avoiding catastrophic medical debt or bankruptcy.[52] It also ensures that health care safety net providers are paid for the care that they deliver, stabilizing the health care system for all users.[53]

The Marketplace's current enrollment policies are not as responsive to the needs of the expansion population. Applicants must wait for open enrollment, which happens once a year, or qualify for a special enrollment period (SEP) based on a narrow set of life changes.[54] Eligible individuals may have to wait one to two months for coverage to begin. People with low incomes cannot afford to pay out of pocket until their coverage starts, and delaying care often worsens or leads to tragic health outcomes as well as utilization of costlier health services, such as hospitalization. If Congress pursues a Marketplace-based Medicaid coverage gap fix, it will need to reshape the ACA's Marketplace's enrollment structure to mirror Medicaid's protections. For example, it would need to have year-round enrollment or create a SEP for expansion enrollees. Otherwise, the people in the Medicaid coverage gap—primarily Black, Latinx, and other people of color, LGBTQ-GNC people, women, and people with chronic health conditions or disabilities—will experience severe barriers to care when they need it.

D. Due process and consumer protections

Any proposed solution to the Medicaid coverage gap should guarantee access to Medicaid's robust due process and consumer protections. Because applicants and enrollees alike have a property interest in Medicaid benefits, they have a constitutional right to receive a meaningful advance notice and a fair hearing if benefits are reduced, denied, or terminated.[55] The Medicaid notice and hearing rights also empower enrollees to challenge unlawful denials of coverage and care.[56] The state agency's notice of an adverse action must inform the applicant or enrollee of the circumstances under which, if they appeal, they can continue to receive benefits at the previously authorized level pending the outcome. This is critical, as Medicaid enrollees cannot afford to pay out of pocket during the months or years a case may be pending.[57] Applicants and enrollees must have a reasonable period of time to request a hearing for adverse actions.[58] Medicaid applicants, enrollees, and their representatives also have important procedural rights for their appeals, such as the rights to a fair hearing before an impartial decision maker, representation at the hearing, and an expedited fair hearing if the time otherwise allowed could jeopardize the person's life, health, or ability to attain, maintain, or regain maximum function.[59] Marketplace policies are often confusing to enrollees, requiring eligibility appeals to go to the Marketplace and service-related appeals made to QHPs or state departments of insurance. If Congress uses the Marketplace to address the Medicaid coverage

gap, it must ensure that enrollees will have the same procedural due process protections that they would receive if applying for or enrolled in Medicaid.

III. Safeguarding the Medicaid Entitlement

Congress should examine how proposals to close the Medicaid coverage gap could preserve or destabilize the Medicaid entitlement nationwide. If Congress pursues a Marketplace approach, it will be politically difficult to prevent some current Medicaid expansion states from seeking to reverse expansion, even with significant incentives to discourage this from happening. If this happens, potentially more people would end up in the Marketplace and, without significant adaptions to incorporate all of Medicaid's protections, without coverage designed to meet their complex health needs.

We are also concerned that a Marketplace approach could lay the foundation for a future Congress to move additional Medicaid population groups to the private health insurance Marketplace, providing less coverage and protections at a higher cost to taxpayers.[60] Ultimately, this approach—particularly if it occurs piecemeal as opposed to a comprehensive national health reform system—could serve as an incremental step toward dismantling the Medicaid entitlement altogether.

IV. U.S. Health Care Spending

Among peer high-income countries, the U.S. has the highest health care expenditures and worst coverage.[61] Currently, subsidized Marketplace coverage is substantially costlier to society than Medicaid coverage. A study published in *JAMA Network Open* earlier this year found that overall health care spending was 80 percent higher among Marketplace-eligible adults than among Medicaid eligible adults.[62] This cost difference has been a key consideration in federal health care reform design. It led the ACA's architects to cover low-income people up to 133 percent FPL through Medicaid rather than subsidized Marketplace coverage.[63]

Today, this means that expanding subsidized Marketplace coverage to the millions of people in the coverage gap would be costlier than Medicaid coverage. Assuming Medicaid's cost protections will be incorporated in any coverage gap solution to protect individuals from higher costs, the overall costs of a coverage gap solution will be higher if the Marketplace is used. The federal government would pay 100 percent of the care (absent individuals' contributions) rather than the state contributing 10 percent. Moreover, given concerns about backsliding in states that have already expanded, the federal government's total spending on such a solution may reach beyond the current non-expansion states, either through incentive payments to

keep states from reversing expansion or by enrolling more people in Marketplace coverage. Although a cost estimate for a federally administered Medicaid program is unavailable at the time of this writing, research suggests that such a program could have lower expenditures if it is designed in a way that reduces administrative complexity.[64]

V. Conclusion

The principles in this paper provide a framework for creating an equitable solution to the Medicaid coverage gap. The millions of people in the coverage gap—largely Black, Latinx, and other people of color in the South, and disproportionately LGBTQ-GNC people, women, people with chronic health conditions or disabilities, and people who live at the intersections of multiple identities—already bear the brunt of oppressive systems that drive vast health inequities. They deserve equitable access to comprehensive health coverage and tailored protections to match. The ACA intended to cover them through Medicaid because it is designed to comprehensively meet their complex needs. **Any coverage gap proposal—be it a federally administered Medicaid program or reshaped Marketplace coverage—must effectively ensure access to Medicaid's robust protections**. Otherwise, a coverage gap "fix" will create a system of separate and unequal health coverage for people in the gap, perpetuating racial and other injustices in health and creating a new coverage gap.

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[1] Special thanks to Leo Cuello, Mara Youdelman, and Jane Perkins for their thoughtful review, and to Dave Machledt and all the above for their thought partnership on this paper.
[2] Immigrants without documentation were never included in the Senate or House bills.
[3] Although the statute sets the eligibility level at 133 percent of the FPL, a 5 percent income disregard is added, raising the effective eligibility threshold to 138 percent of the FPL—in 2021, $17,774.40 for an individual and $24,039.60 for a couple living in the 48 contiguous states and DC. *U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs*, OFF. OF THE ASSIS. SEC. FOR PLANNING & EVALUATION (Jan. 26, 2021), https://aspe.hhs.gov/2021-poverty-guidelines.
[4] *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012).
[5] At the time of this writing, thirty-seven states (including DC) have implemented Medicaid expansion. Oklahoma's new Medicaid expansion coverage goes into effect July 1, 2021. *Status of State Medicaid Expansion Decisions: Interactive Map*, KFF (May 10, 2021), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/. On August 4, 2020, Missouri voters passed a ballot initiative to expand Medicaid, but on June 24, 2021, the State Circuit Court of Cole County blocked implementation. Stephanie Doyle v. Jennifer Tidball, No. 21AC-CC00186 (Mo. C.C. of Cole County June 23, 2021).
[6] *Medicaid Expansion Enrollment as of June 2019*, Kaiser Family Foundation (KFF), https://www.kff.org/health-reform/state-indicator/medicaid-expansion-

enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[7] *See* Madeline Guth et al., *The Effects of Medicaid Expansion Under the ACA: Studies from January 2014 to January 2020*, KFF (Mar. 17, 2020) https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/; Sarah Miller et al., *Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data*, NAT'L BUREAU OF ECON. RESEARCH (Jul. 2019), https://www.nber.org/papers/w26081 (finding that while mortality rates trended similarly among expansion and non-expansion states prior to the ACA, expansion states have experienced significantly reduced mortality relative to their non-expansion counterparts); Madeline Guth et al., *Effects of the ACA Medicaid Expansion on Racial Disparities in Health and Health Care*, KFF (Sep. 30, 2020), https://www.kff.org/medicaid/issue-brief/effects-of-the-aca-medicaid-expansion-on-racial-disparities-in-health-and-health-care/; Jesse Cross-Call, *Medicaid Expansion Has Helped Narrow Racial Disparities in Health Coverage and Access to Care*, CTR. ON BUDGET & POL'Y PRIORITIES (CBPP) (Oct. 21, 2020), https://www.cbpp.org/research/health/medicaid-expansion-has-helped-narrow-racial-disparities-in-health-coverage-and; Lindsey Dawson et al., The Affordable Care Act and Insurance Coverage Changes by Sexual Orientation, KFF (Jan. 18, 2018), https://www.kff.org/racial-equity-and-health-policy/issue-brief/the-affordable-care-act-and-insurance-coverage-changes-by-sexual-orientation/; *Medicaid Expansion Impacts on Insurance Coverage and Access to Care*, ASPE OFF. OF HEALTH EQUITY 9 (Jan. 18, 2017), https://aspe.hhs.gov/system/files/pdf/255516/medicaidexpansion.pdf.

[8] *See, e.g.*, Daniel Lanford & Jill Quadago, *Implementing ObamaCare: The Politics of Medicaid Expansion Under the Affordable Care Act of 2010*, 59(3) SOCIOLOGICAL PERSPECTIVES (Jul. 14, 2015) (finding a significant negative relationship between state-level racial resentment and Medicaid expansion adoption, i.e., higher racial resentment is significantly associated with a lower likelihood of state adoption), https://doi.org/doi:10.1177/0731121415587605; Colleen Grogan & Sunggeun Park, *The Racial Divide in State Medicaid Expansions*, 43(3) J. HEALTH POL., POL'Y, & L. (Jun. 1, 2017) (finding that public support on Medicaid expansion may be racialized, white opinion is highly correlated with measures of state-level racial resentment, and states are only responsive to white opinion, raising questions about to whom states are democratically accountable on health policy decisions), https://read.dukeupress.edu/jhppl/article/42/3/539/13927/The-Racial-Divide-in-State-Medicaid-Expansions.

[9] While models estimating the number of people in the Medicaid coverage gap vary, Urban Institute estimates that if the then-fourteen non-expansion states had expanded eligibility in 2020, 4.4 million fewer people would have been uninsured that year. Matthew Buettgens, *Medicaid Expansion Would Have a Larger Impact Than Ever During the COVID-19 Pandemic*, Urban Inst. (Jan. 2021), https://www.urban.org/research/publication/medicaid-expansion-would-have-larger-impact-ever-during-covid-19-pandemic#:~:text=We%20find%20that%20if%20the,even%20more%20under%20the%20pandemic; *See also*, Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KFF (Jan. 21, 2021), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/ (illustrating that across the 12 states that have neither implemented expansion nor passed ballot initiatives to do so, 97 percent of the adults in the coverage gap live in Southern states. The South has higher numbers of uninsured adults with low incomes than other regions, more limited Medicaid eligibility, and accounts for eight of the twelve states that have opted not to expand Medicaid. In addition, Black people are more likely than their

white counterparts to be uninsured.); Jesse Cross-Call, *supra* note 7 (estimating that in Mississippi, nearly 60 percent of people in the coverage gap are BIPOC and nearly all are Black, non-Hispanic people; in Texas, over 70 percent of people in the coverage gap are BIPOC, most of whom are Hispanic; in all states, BIPOC, especially Black people, disproportionately fall into the Medicaid coverage gap); *see also* Teresa Wilz, *Many African-Americans Fall into a Health 'Coverage Gap'*, THE PEW CHARITABLE TRUSTS (Jan. 26, 2015), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/1/26/many-african-americans-fall-into-a-health--coverage-gap; Gideon Lukens & Breanna Sharer, *Closing the Medicaid Coverage Gap Would Help Diverse Group and Narrow Racial Disparities*, CBPP (Jun. 20, 2021), https://www.cbpp.org/research/health/closing-medicaid-coverage-gap-would-help-diverse-group-and-narrow-racial.

[10] *See* L. Silvia Muñoz-Price et al., *Racial Disparities in Incidence and Outcomes Among Patients with COVID-19*, 3(9) JAMA NETWORK OPEN (Sep. 25, 2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2770961; Samantha Artiga et al., *Changes in Health Coverage by Race and Ethnicity Since the ACA, 2010–2018*, KFF (Mar. 5, 2020), https://www.kff.org/racial-equity-and-health-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/; Samantha Artiga et al., *Racial Disparities in Maternal and Infant Health: An Overview*, KFF (Nov. 10, 2020), https://www.kff.org/report-section/racial-disparities-in-maternal-and-infant-health-an-overview-issue-brief; Adam Searing & Adaora Adimora, *HIV and Medicaid Expansion: Failure of Southern States to Expand Medicaid Makes Elimination of HIV Infection in the United States Much Harder to Achieve*, GEORGETOWN CTR. ON CHILDREN & FAMILIES (Nov. 2020), https://ccf.georgetown.edu/2020/11/29/hiv-and-medicaid-expansion-failure-of-southern-states-to-expand-medicaid-makes-elimination-of-hiv-infection-in-the-united-states-much-harder-to-achieve/; *see also Racial Inequities in HIV*, 7(7) LANCET HIV (Jul. 2020), thelancet.com/journals/lanhiv/article/PIIS2352-3018(20)30173-9/fulltext; *Addressing Health Disparities in Diabetes*, CTRS FOR DISEASE CONTROL & PREV. (Apr. 15, 2019), https://www.cdc.gov/diabetes/disparities.html.

[11] American Rescue Plan Act of 2021, 117th Cong. § 3105 (2021).

[12] Leighton Ku & Erin Brantley, *The Economic and Employment Effects of Medicaid Expansion Under the American Rescue Plan*, https://www.commonwealthfund.org/publications/issue-briefs/2021/may/economic-employment-effects-medicaid-expansion-under-arp (finding that if the then-fourteen non-expansion states expanded Medicaid under the ARP, they would spend $5 billion in state matching costs in 2022 but receive $49 billion in increased federal revenue).

[13] *See* letter from Senators Jon Ossoff and Raphael Warnock to U.S. Senate Majority Leader Charles Schumer and Senate Minority Leader Mitch McConnel (May 26, 2021), https://www.warnock.senate.gov/wp-content/uploads/2021/05/5.26.21-Medicaid-Expansion-Letter-.pdf; letters from the Congressional Tri-Caucus to Speaker of the U.S. House of Representatives Nancy Pelosi, U.S. Senate Majority Leader Charles Schumer, President Joe Biden, Vice President Kamala Harris (Jul. 16, 2021), https://robinkelly.house.gov/media-center/press-releases/congressional-tri-caucus-leaders-call-for-biden-administration-to; letter to Members of Congress from the Leadership Conference on Civil and Human Rights (May 27, 2021), https://civilrights.org/resource/close-the-medicaid-coverage-gap-to-advance-health-equity/.

[14] Abbi Coursolle, David Machledt, & Wayne Turner, *What Makes Medicaid, Medicaid?—Access*, NAT'L HEALTH LAW PROG. 4 (Mar. 30, 2017), https://healthlaw.org/resource/what-makes-medicaid-medicaid-access/; *see also* Nathan D. Shippee & Katherine D. Vickery, The Complex Needs of Medicaid

Expansion Enrollees with Very Low Incomes, The Commonwealth Fund (May 31, 2018), https://www.commonwealthfund.org/publications/issue-briefs/2018/may/complex-needs-medicaid-expansion-enrollees-very-low-incomes.
[15] *Id.*
[16] *Id.*
[17] *Id.*
[18] MaryBeth Musumeci et al., *Key State Policy Choices About Medical Frailty Determinations for Medicaid Expansion Adults*, KFF (Jun. 26, 2019), https://www.kff.org/report-section/key-state-policy-choices-about-medical-frailty-determinations-for-medicaid-expansion-adults-issue-brief/#endnote_link_410853-29.
[19] *See* ASPE, *supra* note 7.
[20] *See* Abbi Coursolle et al., *supra* note 14, at 4.
[21] *See* ASPE, *supra* note 7.
[22] ABPs, formerly known as Medicaid benchmarks and benchmark-equivalents, have existed since the Deficit Reduction Act of 2005 authorized states to develop alternative Medicaid benefit packages for select groups of Medicaid enrollees. While the allowance of ABP was an understandable political compromise for the ACA, we hope one day Congress will move all Medicaid expansion enrollees into State plan benefits, which are the best standard for meeting their needs. 42 U.S.C. § 1396a(k)(1). 78 Fed. Reg. 42160 (July 15, 2013); *see generally* 42 U.S.C. § 1396u-7; 42 C.F.R. § § 440.300-440.390.
[23] See 42 U.S.C. §§ 1396a(k), 1396b(i)(26); *Medicaid: Essential Health Benefits in Alternative Benefit Plans*, 78 Fed. Reg. 42,192 (July 15, 2013); Michelle Lilienfeld*, Alternative Benefit Plans for the Medicaid Expansion Population: Trends in Approved Benefit Plans and Tools for Advocates*, NAT'L HEALTH LAW PROG. 5 (Jul. 28, 2014), https://healthlaw.org/resource/alternative-benefit-plans-for-the-medicaid-expansion-population/; Medicaid Alternative Benefit Plan Coverage: Frequently Asked Questions, CONGRESSIONAL RESEARCH SERV. 13–14 (Nov. 26, 2018), https://www.everycrsreport.com/files/20181126_R45412_fdaa79aee4c43e93d96ff88a776cabaae375026f.pdf (noting that states have largely aligned their benefit coverage with State plans).
[24] *See* Michelle Lilienfeld*, supra* note 23, at 5.
[25] Of note, "alignment" does not mean ABP benefits are identical to State plan services—they may cover additional services as well. *See* CONGRESSIONAL RESEARCH SERV., *supra* note 23, at 13.
[26] 42 U.S.C. § 1396u-7(a)(2)(B); *see also* Michelle Lilienfeld*, supra* note 23, at 5.
[27] Musumeci, *supra* note 18.
[28] 42 C.F.R. § 440.230(b); see also 42 U.S.C. § 1396a(a)(10)(B).
[29] 42 C.F.R. § 440.230(c).
[30] *See* Abbi Coursolle et al., *supra* note 14, at 4.
[31] EPSDT is applicable to expansion enrollees aged 19–21. 42 U.S.C. §§ 1396a; 1396d.
[32] 42 C.F.R. § 440.345; Abbi Coursolle, David Machledt, & Catherine McKee, *Current Issues in NEMT*, Nat'l Health Law Prog. (Nov. 4, 2016), https://healthlaw.org/resource/issue-brief-current-issues-in-nemt/.
[33] *See*, *e.g.*, Jennifer Lav, *Policy Implications of Repealing the IMD Exclusion*, NAT'L HEALTH LAW PROG. (May 17, 2018), https://healthlaw.org/resource/policy-implications-of-repealing-the-imd-exclusion/.
[34] 42 U.S.C. § 1396u-7(b).

[35] This protection ensures that enrollees can access health care from provider settings tailored to the special needs, priorities, and cultures of the communities that they serve. 42 U.S.C. § 1396u-7(b)(4); 42 C.F.R. § 440.365.
[36] 42 U.S.C. § 1395 *et seq*.
[37] 42 U.S.C. 1905(I)(2)(B); 42 U.S.C. § 254b *et seq*.
[38] *See, e.g.*, Naomi Newman et al., *In Pursuit of Whole Person Health: Leveraging Medicaid Manage Care & 1115 Wavers to Address SDOH*, Manatt (Oct. 28, 2020), https://www.manatt.com/insights/newsletters/manatt-on-health-medicaid-edition/in-pursuit-of-whole-person-health-leveraging-medic.
[39] Leo Cuello, *Medicaid Expansion Update: Premium Assistance and Demonstrations*, 22 HEALTH ADVOCATE 23 (Mar. 18, 2014), https://healthlaw.org/resource/health-advocate-medicaid-expansion-and-premium-assistance/.
[40] *See, e.g.*, *Evaluations of Integrated Care Models for Dually Eligible Beneficiaries: Key Findings and Research Gaps*, MACPAC 8 (Aug. 2020), https://www.macpac.gov/wp-content/uploads/2019/07/Evaluations-of-Integrated-Care-Models-for-Dually-Eligible-Beneficiaries-Key-Findings-and-Research-Gaps.pdf.
[41] 42 U.S.C. §§ 1396o, 1396o-1; *See* David Machledt & Jane Perkins, *Medicaid Premiums and Cost Sharing*, NAT'L HEALTH LAW PROG. 1 (Mar. 26, 2014), https://healthlaw.org/resource/medicaid-premiums-and-cost-sharing/.
[42] *Id*.
[43] 42 U.S.C. § 1396o (Social Security Act § 1916); 42 U.S.C. § 1396o-1 (Social Security Act § 1916A).
[44] 42 C.F.R. § 447.52(e).
[45] *See* David Machledt & Jane Perkins, *supra* note 41, at 24.
[46] 42 C.F.R. § 438.106.
[47] *See*, *e.g.*, *Marketplace Enrollment as a Share of the Potential Marketplace Population*, KFF, https://www.kff.org/health-reform/state-indicator/marketplace-plan-selections-as-a-share-of-the-potential-marketplace-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (Dec. 16, 2020) (estimating that in 2020, about one in three people who were eligible to enroll in the Marketplace did so); Justin Giovannelli & Emily Curran, *Factors Affecting Health Insurance Enrollment Through the State Marketplaces: Observations on the ACA's Third Open Enrollment Period*, Commonwealth Fund 4–5 (Jul. 2016), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2016_jul_1887_giovannelli_factors_affecting_enrollment_rb_v3.pdf.
[48] *See* David Machledt & Jane Perkins, *supra* note 41, at 24.
[49] 2 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.906.
[50] 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.915.
[51] *Id*.
[52] *See* Abbi Coursolle et al., *supra* note 14, at 4.
[53] *Id*.
[54] 45 C.F.R. § 155.420; 45 C.F.R. § 155.410(f).
[55] U.S. CONST. amend. XIV, § 1.; *See Mathews v. Eldridge*, 424 U.S. 319, 348 (1976) (holding due process rights vary among property interests and requires consideration of the private interest affected by the action, the risk of an erroneous deprivation of that interest through the procedures being used

and the probable value of additional procedures, and the government's interest, including administrative and fiscal burdens the additional procedural requirement would entail); *Goldberg v. Kelly*, 397 U.S. 254 (1970) (holding that when public benefits are terminated, the beneficiary has due process rights to an effective notice and pre-termination hearing); *see generally Bd. of Regents v. Roth*, 408 U.S. 564, 577 (1972); *see also, e.g.*, 42 C.F.R. § 431.205(d).

[56] 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.200.

[57] *See* Kim Lewis & Wayne Turner, *What Makes Medicaid, Medicaid?—Consumer Protections and Due Process*, NAT'L HEALTH LAW PROG. 9–12 (Mar. 21, 2017), https://healthlaw.org/resource/what-makes-medicaid-medicaid-consumer-protections-and-due-process/.

[58] *Id*. at 10.

[59] *Id*. at 11; 42 C.F.R. § 431.224(a).

[60] Leo Cuello, *supra* note 39, at 22.

[61] Health-care expenditure and health policy in the USA versus other high-spending OECD countries, OECD, https://www.oecd.org/els/health-systems/health-in-united-states.htm (last visited Jun. 22, 2021).

[62] Heidi Allen et al., *Comparison of Utilization, Costs, and Quality of Medicaid vs. Subsidized Private Health Insurance for Low-Income Adults*, JAMA NETWORK OPEN (Jan. 5, 2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774583.

[63] While both the House and Senate wrote slightly different drafts of the ACA, both chambers came to the conclusion that Medicaid expansion, not subsidized Marketplaces, was the right choice for covering lower income populations. *See* Tom Cohen et al., *House, Senate Health Care Bills Grow Further Apart*, CNN POLITICS, (Dec. 10, 2009) http://www.cnn.com/2009/POLITICS/12/09/health.care.differences/index.html.

[64] *See, e.g.*, Emily Gee & Topher Spiro, *Excess Administrative Costs Burden the U.S. Health Care System*, CTR. FOR AM. PROG. (Aug. 8, 2019), https://www.americanprogress.org/issues/healthcare/reports/2019/04/08/468302/excess-administrative-costs-burden-u-s-health-care-system/.