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Medicaid at 50: No Longer Limited to the “Deserving” Poor?

David Orentlicher, MD, JD*

INTRODUCTION

For the first fifty years of its existence, Medicaid suffered from a serious defect—while it was adopted to meet the health care needs of the poor, it was designed only to meet the needs of the so-called “deserving” poor. Rather than providing Medicaid benefits to all persons who fell below the federal poverty level of income (or met some other measure of indigence), Congress limited eligibility to those categories of the poor that were viewed as especially deserving of assistance. These categories included children, pregnant women, single caretakers of children, and disabled persons.¹

Poor people in these groups could not fairly be held accountable for their inability to afford health care insurance, for they were not expected to be gainfully employed in the workplace. Whether because of age, medical condition, or responsibilities in the home, the deserving poor could not be blamed for their indigence.²

Nor would providing assistance create perverse incentives. If poor, able-bodied, and childless adults could qualify for Medicaid, they might be less inclined to seek employment and an income that would permit them to afford a private health insurance plan. But Medicaid recipients were not supposed to be looking for jobs.

The Medicaid program’s distinction between the indigent who deserved public assistance and those who did not has a long pedigree. Rooted in England’s Elizabethan Poor Laws at the turn of the seventeenth century and colonial practices in America, the idea of a deserving poor had been institutionalized in state cash assistance laws throughout the United States by the early twentieth century.³ The

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1. Jane Perkins, *Medicaid: Past Successes and Future Challenges*, 12 HEALTH MATRIX 7, 11-13 (2002).

2. David Orentlicher, *Rights to Healthcare in the United States: Inherently Unstable*, 38 AM. J. L. & MED. 326, 331 (2012).

3. ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID 5-6 (2003). For a detailed discussion of the Elizabethan Poor Laws, see Jacobus

deserving poor included seniors, children and their single mothers, and the unemployable blind—indigent persons who “could not be labeled social deviates or paupers by choice.”⁴ Similar categories for eligibility appeared in the cash support provisions of the Social Security Act of 1935, with the addition of a category for the totally and permanently disabled in 1950. Limiting assistance to the deserving poor would ensure that benefits were available “for those made dependent through no fault of their own.”⁵ When Medicaid was passed in 1965 as a hastily drafted amendment to the Medicare bill,⁶ Congress grafted Medicaid’s eligibility standards onto existing welfare categories.⁷

With its cramped criteria for eligibility, pre-ACA Medicaid never realized its public perception as a health care program for the poor. Indeed, it extended its coverage to less than half of the poor in the United States during its first fifty years of existence.⁸

The Affordable Care Act (ACA) seemingly has abandoned Medicaid’s conception of the deserving poor with its expansion of the Medicaid program to all persons up to 138% of the federal poverty level. One no longer needs to be a child, disabled, pregnant, or a caretaker of a child to be eligible for Medicaid; it is sufficient simply to be poor. Or as Chief Justice John Roberts observed in *National Federation of Independent Business v. Sebelius*, the Supreme Court’s primary ACA case, Medicaid “is no longer a program to care for the neediest among us.”⁹ The Medicaid expansion is a “shift in kind, not merely degree.”¹⁰

In this essay, I consider the significance of this major modification of the Medicaid program. Does the ACA signal a more generous view of the deserving poor, or even an abandonment of the distinction between the poor and the “deserving” poor? Or does the ACA tell us more about the nature of health care

tenBroek, *California's Dual System of Family Law: Its Origin, Development, and Present Status: Part I*, 16 STAN. L. REV. 257, 258-87 (1964).

4. STEVENS & STEVENS, *supra* note 3, at 6. For an analysis of the “mothers’ pension” laws, see Children’s Bureau, *Laws Relating to “Mothers’ Pensions” in the United States, Denmark and New Zealand*, U.S. DEP’T. LAB. (1914), <http://www.mchlibrary.info/history/chbu/20375.pdf>.

5. STEVENS & STEVENS, *supra* note 3, at 7. The cash support programs included the federal welfare program, originally “Aid to Dependent Children” (ADC), then “Aid to Families with Dependent Children” (AFDC), and since 1996, “Temporary Assistance to Needy Families” (TANF). Edward J. McCaffery, *The Burdens of Benefits*, 44 VILL. L. REV. 445, 473-81 (1999).

6. See, e.g., JONATHAN ENGEL, POOR PEOPLE’S MEDICINE: MEDICAID AND AMERICAN CHARITY CARE SINCE 1965 49-50 (2006); Emily Friedman, *The Compromise and the Afterthought: Medicare and Medicaid after 30 Years*, 274 JAMA 278, 280 (1995).

7. STEVENS & STEVENS, *supra* note 3, at 61-62; Friedman, *supra* note 6, at 279.

8. In 1999, Medicaid provided coverage to only 37 percent of non-elderly Americans with incomes below the federal poverty level. Perkins, *supra* note 1, at 13. By 2012, coverage reached 45 percent of the non-elderly poor. *Medicaid: A Primer*, KAISER FAM. FOUND. 8 (2013), <http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf>.

9. Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2606 (2012).

10. *Id.* at 2605.

than about societal views of the poor? And what do the answers to these questions tell us about the durability of the Medicaid expansion? Can we expect Congress to maintain the ACA's revision of Medicaid for the next fifty years? As I will discuss, it seems that the Medicaid expansion reflects concerns about the high costs of health care rather than an evolution in societal thinking about the "deserving" poor. As a result, the expansion may not provide a stable source of health care coverage for the expansion population.

I. DOES THE MEDICAID EXPANSION REPRESENT A RECONCEPTION OF THE DESERVING POOR OR EVEN A REJECTION OF THE DISTINCTION BETWEEN THE DESERVING POOR AND THE OTHER POOR?

Perhaps Congress realized that Medicaid's definition of the deserving poor was too narrow and excluded many people who were just as deserving of assistance as those who qualified for pre-ACA Medicaid. With Medicaid reaching less than half of those who fell below the federal poverty level, there were many indigent persons who did not have access to health care insurance and lacked any meaningful prospect of becoming able to afford coverage.

Moreover, their limited prospects for obtaining coverage could persist for a long time. Among American children whose families fall in the bottom fourth of the income distribution, only about 10% achieve a key qualification for good employment—a college degree.¹¹ The United States is not a land of opportunity for many people at the bottom of the economic ladder, with lower levels of economic mobility than other Western, developed countries, including Canada, Denmark, and France.¹² In the United States, people's chances of prospering depend much more on the wealth of their parents than upon their character.

The idea that if poor families were ineligible for traditional Medicaid, it meant that they lacked initiative was also belied by other data. Among the non-elderly uninsured,¹³ for example, 63% lived in families with one or more full-time workers, and another 16% lived in families with part-time workers.¹⁴ Working hard and playing by the rules did not guarantee that someone would have health care

11. Martha J. Bailey & Susan M. Dynarski, *Gains and Gaps: Changing Inequality in U.S. College Entry and Completion*, 26 fig.3 (Nat'l Bureau of Econ. Research, Working Paper No. 17633, 2011), <http://www.nber.org/papers/w17633>. For children whose families are in the top fourth of the income distribution, the college graduation rate exceeds 50 percent. *Id.*

12. *Economic Mobility: Is the American Dream Alive and Well?*, PEW CHARITABLE TR. 4-5 (2007), http://www.pewtrusts.org/~media/legacy/uploadedfiles/wwwpewtrustsorg/reports/economic_mobility/EMP_AmericanDreamReportpdf.pdf.

13. Almost all of the elderly are insured, primarily because of Medicare. *The Uninsured: A Primer*, KAISER FAM. FOUND. 1 (2013), <http://kaiserfamilyfoundation.files.wordpress.com/2013/10/7451-09-the-uninsured-a-primer-key-facts-about-health-insurance.pdf>.

14. *Id.* at 6.

insurance in pre-ACA America.

The Great Recession that immediately preceded the enactment of the ACA only reinforced this reality. Millions of Americans became unemployed and millions more became underemployed because of economic forces beyond their control. As a result, they lost their health care benefits, as well as the ability to replace those benefits with the purchase of an individual policy. The ranks of the uninsured rose by nearly six million between 2007 and 2010.¹⁵

Not only were fewer people employed; as the average duration of unemployment lengthened to post-WWII highs,¹⁶ chronic unemployment became a more serious problem, especially for persons over age fifty-five.¹⁷ Through no fault of their own, many Americans who had worked productively for decades could no longer secure gainful employment and the health care coverage that comes with it.

In addition, the concept of a “deserving” poor rested in part on inaccurate stereotypes about indigent persons exploiting the existence of public welfare programs by turning to them instead of finding a job. People generally prefer gainful employment that allows them to pay for their benefits rather than relying on government subsidies. Indeed, the stigma of being a recipient of food stamps, Medicaid, or other programs deters many eligible people from enrolling.¹⁸

In short, for a number of reasons, it became clear that it did not make sense to hold more than half of the poor personally responsible for their lack of health care insurance because they were not part of the “deserving” poor. Rather, it made much more sense to expand the definition of the deserving poor or simply jettison that concept entirely.

II. DOES MEDICAID REFLECT A REJECTION OF THE CONCEPT OF A DESERVING POOR ONLY FOR HEALTH CARE?

Instead of considering the Medicaid expansion in isolation, it may make more sense to consider the expansion in its overall ACA context. Perhaps Congress no longer tries to distinguish between the deserving poor and the rest of the poor under Medicaid because health care services are special in a way that other social services are not. And indeed, as Justice Roberts observed, Congress did not simply expand the Medicaid program by itself in 2010. Rather, it passed the expansion as “an

15. *Id.* at 9.

16. Don Lee, *Long-term Unemployed Still at Record Levels*, L.A. TIMES, Sept. 10, 2014, <http://www.latimes.com/business/la-fi-longterm-jobless-20140910-story.html>.

17. In February 2010, the average duration of unemployment for workers 55 years and older was 35.5 weeks, compared to 30.3 weeks for workers age 25 to 54 and 23.3 weeks for workers between 16 and 24. Emily Sok, *Record Unemployment Among Older Workers Does Not Keep Them Out of the Job Market*, U.S. BUREAU LAB. STAT. (Mar. 2010), http://www.bls.gov/opub/ils/summary_10_04/older_workers.htm.

18. Orentlicher, *supra* note 2, at 332.

element of a comprehensive national plan to provide universal health insurance coverage.”¹⁹

Pre-ACA America had a multi-tiered system of health care coverage. Most Americans relied on their employment to obtain their health care benefits, and there were public programs for those who did not—as long as they were deserving of assistance. As discussed, pre-ACA Medicaid was a program for the deserving poor. The VA health care system is a program for veterans whose benefits are given in recognition of their service to the country. Medicare is a program for another “deserving” class of citizens—the elderly.

Medicare recipients are seen as deserving of their coverage for a number of reasons. First, because of their age, seniors have relatively high medical costs—when Medicare was passed, average health care expenses for people sixty-five or older were twice the average expenses for younger persons.²⁰ At the same time, the elderly are less able to afford health care bills. Medicare kicks in when people may no longer be working and are experiencing a greatly reduced income. Moreover, their reduced income does not reflect a lack of initiative or an attempt to exploit the system. Rather, Medicare recipients have made their contributions to society and moved into a well-deserved retirement.²¹ Medicare is a program based on just deserts for a third reason: people qualify themselves and their spouses for Medicare in the same way that they qualify themselves and their spouses for Social Security—by making payments to the government during their working lives.²² In other words, while a public assistance program for younger persons might stifle initiative and promote dependence, the Medicare program became available for persons who were not expected to be active workers and who in fact had earned their eligibility.²³ Medicare recipients would truly be “deserving” of their benefits.²⁴

If one is trying to create a system of universal coverage,²⁵ one cannot make distinctions among citizens in terms of their deserts. One cannot reserve public assistance only for seniors, veterans, or a limited concept of the deserving poor. As mentioned, when Congress took that approach, the Medicaid program did not

19. Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. at 2606.

20. JONATHAN OBERLANDER, *THE POLITICAL LIFE OF MEDICARE* 23-24 (2003).

21. *Id.*; THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* 11-12 (2d ed. 2000).

22. More precisely, people become eligible for premium-free Medicare Part A (coverage for hospital care) through their Medicare payroll deductions or those of their spouses. In the absence of the required payroll deductions, seniors pay a premium for their Part A benefits. John Bigler et al., *An Overview of Social Security, Medicare and Medicaid*, N.Y. ST. B.A. J., Sept.–Oct. 1993, at 14, 16.

23. MARMOR, *supra* note 21, at 15-16, 96.

24. OBERLANDER, *supra* note 20, at 24-25.

25. In fact, the ACA is not a plan for universal coverage. Because of exemptions, exclusions, and the limits of its subsidies for middle-income families, the ACA will leave about 26 million US residents uncovered, even with full implementation of its provisions. *The Uninsured: A Primer*, *supra* note 13, at 20.

reach even half of the indigent. If the country wants a system of universal coverage, it has to ensure that everyone has meaningful access to a health care insurance policy or program.

Thus, rather than determining benefits in terms of *how* a person came to need assistance procuring health care coverage, the ACA determines benefits simply on the basis of *whether* the person needs help in affording coverage. If a person earns no more than 138 % of the federal poverty level, the person qualifies for Medicaid, regardless of why the person is poor.²⁶ And the ACA does not limit its financial assistance just to all of the poor. Middle-income families that have to purchase their own insurance plans because they do not receive coverage as a benefit of employment are eligible for governmental subsidies as long as they earn no more than 400% of the federal poverty level.²⁷

In this health-care-is-special view, Congress may have come to the conclusion that because health care has become so expensive, it is no longer reasonable to assume that most families can afford health care coverage on their own or that the uninsured can be held personally responsible for their lack of coverage. Indeed, two-thirds of Americans fall below the ACA's maximum threshold of 400% of FPL to qualify for financial subsidies.²⁸

The special nature of health care may also reflect the interconnected nature of the health care system. Even when people cannot pay for medical care, they still receive emergency treatment and other kinds of care. Hospitals, doctors, and other providers meet many of the health care needs of the indigent, whether out of charitable impulse, the duty to provide care under the Emergency Medical Treatment and Active Labor Act (EMTALA), or for other reasons. But doing so comes at a cost that is ultimately borne in large part by the insured. To some extent, the costs of caring for the uninsured are made up by higher prices for the insured, translating into higher insurance premiums, and to some extent, the costs of caring for the uninsured are made up through taxes on the insured to pay for public programs. As long as the insured cannot isolate themselves from the uninsured in the health care system, there is greater pressure to design a system that works well

26. 42 U.S.C. § 1396a(a)(10)(A)(i)(VII) (2012) (establishing Medicaid eligibility for those whose income does not exceed 133 percent of the poverty line). In addition, 5 percent of an applicant's income is disregarded, effectively raising the eligibility threshold to 138 percent. *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*, CONG. BUDGET OFF. 7 n.13 (2012),

<http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>.

27. 26 U.S.C. § 36B (2012).

28. *Distribution of the Total Population by Federal Poverty Level (above and below 400% FPL)*, KAISER FAM. FOUND., <http://kff.org/other/state-indicator/population-up-to-400-fpl> (last visited Dec. 7, 2014). This does not mean that two-thirds of families will actually receive subsidies. Many families who earn less than 400 percent of FPL will obtain their health care coverage from their employer and therefore not need subsidies to purchase their coverage on health insurance exchanges.

for everyone.

Which of the two explanations seems more plausible? Has America discarded previous concepts of the deserving poor, or does the ACA tell us more about our views about health care than about the poor?

The latter seems more plausible. While the ACA extends health care coverage to all of the poor, the country has not revised its eligibility criteria for food stamps, housing, cash assistance, or other social welfare programs. Nor does it seem inclined to do that.²⁹ Moreover, much of the support for the ACA was driven by the fact that health care was becoming unaffordable for too many, even those in the middle class. A diagnosis of heart disease, cancer, or other “pre-existing condition” would lead insurers to double premiums or drop coverage entirely, leaving many people unable to secure the health care coverage they or their family members needed. Without adequate coverage—whether due to uninsurance or underinsurance—many people found themselves forced into bankruptcy by substantial medical bills. Rather than reflecting concern for the uninsured poor, the ACA may have been driven more by concern for the uninsurable middle class. Indeed, it is much easier to enact major social welfare programs when they serve the general public and not just the indigent. Most importantly, the primary goal of the ACA was to create a system of universal coverage, with the Medicaid expansion being just one element of the new system. Concern for the poor played a role but only as part of a broad concern about access to health care insurance.

III. IMPLICATIONS FOR THE FUTURE

An important question is whether the ACA’s promise of health care for all of the poor will be realized over the next fifty years. Will Medicaid truly become a program for every poor person, not just the “deserving” poor?³⁰

29. The experience of the Great Depression reinforces this view. With poverty widespread during that period, a federal relief program was established that provided assistance to the poor without trying to distinguish between the deserving poor and the other poor. Once prosperity returned, however, the traditional distinction between the deserving poor and the other poor reemerged. STEVENS & STEVENS, *supra* note 3, at 7.

30. Of course, in states that do not take up the ACA expansion, Medicaid will remain as it was before the ACA. However, there is good reason to think that many of the hold-out states will opt for the expansion within the next few years. Expansion states will reduce the size of their uninsured population, and for a few reasons, they also should be better off fiscally. The federal government will pick up 90 percent of the costs of the expansion, the expense of uninsured care will decrease, and expansion states will enjoy an economic stimulus from the new Medicaid spending. Mark Hall, *States’ Decisions Not to Expand Medicaid*, 92 N.C. L. REV. 1459, 1471-75 (2014). Moreover, the Department of Health and Human Services has allowed states flexibility to design their own versions of the Medicaid expansion. Arkansas, for example, will insure its new Medicaid recipients with private coverage purchased on the state’s health insurance exchange. David K. Jones, Phillip M. Singer & John Z. Ayanian, *The Changing Landscape of Medicaid Practical and Political Considerations for Expansion*, 311 JAMA 1965 (2014).

Unfortunately, there are reasons to be concerned. Two reasons in particular stand out. First, the ACA did not roll all of the poor into a single Medicaid program. Rather, it preserved the traditional paths into Medicaid for pregnant women, children, caretakers of children, and disabled persons, while adding a new path for the rest of the poor.³¹ Thus, the old “deserving” poor will rely on different statutory provisions than will the newly eligible for their Medicaid coverage. If a future Congress wants to revive the distinction between the deserving poor and the other poor and cut back on the ACA’s Medicaid expansion, it can do so without having to simultaneously reduce the program’s coverage for the old deserving poor. For example, if a future Congress decides to add a requirement that the expansion population be working or engaged in job training to qualify for Medicaid benefits, it can make that change without changing the eligibility criteria for pre-ACA Medicaid programs.³²

Just as Congress maintained the distinction between the deserving poor and the other poor, so too did it maintain the distinction between the poor and the non-poor. The ACA preserved Medicaid as a program for the poor rather than creating a single Medicare-for-all, or even Medicare Advantage-for-all,³³ program that would provide health care coverage for everyone, rich or poor. Rather than putting all Americans into the same health care coverage boat, our health care system will continue to rely on many boats, albeit bigger boats and boats with fewer holes in them.

This is a problem because Americans will not all sail or sink together. The ACA does better by the poor than did pre-ACA Medicaid, but the interests of the poor still are divorced from the interests of the well-to-do. Those with means will continue to receive health care coverage through their employer or themselves, while those of limited means will continue to rely on public subsidies for their coverage. Those who are better off will continue to see Medicaid as a program that they pay for but that primarily serves the needs of the poor.³⁴

31. 42 U.S.C. § 1396a(a)(10)(A)(i) (2012).

32. Of course, even with a reduction from 90 percent, the federal match contribution might still be higher than for pre-ACA Medicaid, for which the federal government picks up roughly 50-75 percent of the costs, with richer states paying a higher share of their Medicaid costs. *Medicaid: A Primer*, *supra* note 8, at 31.

33. Medicare Advantage, or Part C of Medicare, permits Medicare recipients to have Medicare pay for their enrollment in a private health care plan. *Medicare: A Primer*, KAISER FAM. FOUND. 1 (2010), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7615-03.pdf>. In other words, Medicare Advantage is akin to a voucher system.

34. WILLIAM JULIUS WILSON, *THE TRULY DISADVANTAGED: THE INNER CITY, THE UNDERCLASS, AND PUBLIC POLICY* 119 (1987) (noting that taxpayers viewed Medicaid as paying for services provided to welfare recipients but not to themselves). To be sure, there are benefits to everyone when the poor have good health care coverage. As mentioned, most of the uninsured are employed, and they can be more productive and contribute more to the national economy when they are healthier. In addition, the fiscal burden of the Medicaid expansion will be lessened by the fact that there are substantial costs imposed on the public from the expense of the health care that

Government programs such as this in the United States generally lack sufficient political support to ensure adequate funding over time.³⁵ The poor have little influence in the halls of Congress or the statehouses, and the wealthy are inclined to disfavor programs that benefit only the poor. Thus, for example, programs like Social Security and Medicare that serve recipients at all income levels have been far more successful than programs like Medicaid, which target the indigent.³⁶ The Medicaid coverage expansion depends to a substantial extent on the willingness of persons with political influence to fund programs for other people, and experience suggests that their willingness to do so over the long run may be limited.

Indeed, when states have faced challenges to their budgets in difficult economic times, they have often responded by reducing Medicaid eligibility. The Oregon Health Care Plan provides a useful example.³⁷ In the 1990s, Oregon decided to expand its Medicaid program to reach all of its poor residents (i.e., those with a family income up to one hundred percent of the federal poverty level).³⁸ Instead of providing generous benefits for a limited number of the poor, Oregon would provide limited benefits for all of the poor.³⁹ At first, the program was well-funded, and the percentage of uninsured in the state dropped from seventeen percent to eleven percent.⁴⁰ As the Oregon economy stalled and government revenues dropped, however, Oregon raised eligibility thresholds, and within ten years of the plan's implementation Oregon's rate of uninsured had risen to pre-plan levels.⁴¹ Similarly, fiscal pressures led thirty-eight states to reduce or restrict Medicaid eligibility between 2002 and 2005.⁴² States also have responded to fiscal pressures by reducing benefits and decreasing payments to physicians who provide care to Medicaid recipients.⁴³ In future years, Congress might cut funding for the

the uninsured receive. But these offsetting benefits have not been substantial enough to create a sense that the Medicaid program is a program for everyone.

35. *Id.* at 118-20.

36. *Id.* at 118.

37. Lawrence Jacobs et al., *The Oregon Health Plan and the Political Paradox of Rationing: What Advocates and Critics Have Claimed and What Oregon Did*, 24 J. HEALTH POL. POL'Y & L. 161, 163 (1999); David Orentlicher, *Controlling Health Care Costs Through Public, Transparent Processes: The Conflict Between the Morally Right and the Socially Feasible*, 36 J. CORP. L. 807, 813-14 (2011).

38. Orentlicher, *supra* note 37, at 813-14.

39. *Id.*

40. Jacobs et al., *supra* note 37, at 165-68.

41. Orentlicher, *supra* note 37, at 814.

42. Vernon Smith et al., *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005*, KAISER FAM. FOUND. 26 (2004), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/the-continuing-medicaid-budget-challenge-state-medicaid-spending-growth-and-cost-containment-in-fiscal-years-2004-and-2005-results-from-a-50-state-survey.pdf>

43. Laura Katz Olson, *Medicaid, the States and Health Care Reform*, 34 NEW POL. SCI. 37, 48-51 (2012). To be sure, states also have taken steps to expand Medicaid eligibility, especially for

ACA's Medicaid expansion when the federal budget is squeezed, just as it has cut funding for food stamps in tight budgetary times.⁴⁴

The willingness of the financially secure to sustain the ACA's coverage provisions for the poor may be tested in another way by the ACA's preservation of a dual health care system, with both public and private coverage, rather than adoption of a system based primarily on public coverage. As has happened with Medicaid expansions in the past,⁴⁵ the ACA's new public benefits may to some extent "crowd out" private coverage. That is, people who now have unsubsidized private health care coverage may switch to the expanded Medicaid program or qualify for subsidized private health care coverage. For an employer with a high percentage of low-wage workers, it will be financially advantageous not to provide health care benefits, but to let the employees enroll in Medicaid or purchase a subsidized policy on a health insurance exchange. Indeed, there is anecdotal evidence suggesting that many employers are moving their low-wage employees into Medicaid in response to the ACA's employer mandate.⁴⁶ If crowding out exceeds projections made at the time the ACA was adopted, public subsidies will become more expensive than anticipated for the federal and the state governments, and therefore less sustainable over time.⁴⁷

CONCLUSION

Through the Medicaid expansion, the ACA has done much to ensure that access to health care for the poor is not limited only to a narrow conception of the "deserving" poor. But by still distinguishing between the deserving poor and the other poor under Medicaid's eligibility rules, the ACA may not provide a durable source of health care coverage for the other poor.

How the different interests and pressures will play out over time is uncertain. On one hand, the poor will remain vulnerable in the political process. When budgets are tight, it will continue to be easier for elected officials to reduce spending on the poor than on the middle or upper class. On the other hand, the Medicaid expansion differs in an important way from pre-ACA Medicaid—it is much more of a federal program than a federal-state partnership. While eligibility

children. John E. McDonough, *A Progress Report On State Health Access Reform*, 27 HEALTH AFF. w105, w108 (2008).

44. Ron Nixon, *Senate Passes Long-Stalled Farm Bill, With Clear Winners and Losers*, N.Y. TIMES, Feb. 5, 2014, <http://www.nytimes.com/2014/02/05/us/politics/senate-passes-long-stalled-farm-bill.html>

45. Jonathan Gruber & Kosali Simon, *Crowd-Out 10 Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?*, 27 J. HEALTH ECON. 201 (2008).

46. Anna Wilde Mathews & Julie Jargon, *Companies Try to Escape Health Law's Penalties*, WALL ST. J., Oct. 21, 2014, <http://www.wsj.com/articles/companies-try-to-escape-health-laws-penalties-1413938115>.

47. Mark V. Pauly & Adam A. Leive, *The Unanticipated Consequences of Postponing the Employer Mandate*, 369 NEW ENG. J. MED. 691, 692-93 (2013).

for adults under pre-ACA Medicaid varied from state to state, the Medicaid expansion establishes a uniform standard for eligibility (income up to 138% of the federal poverty level). In addition, the federal government picks up almost all of the costs of the expansion. The federalization of Medicaid should help protect it from erosion because the federal government is better able than states to maintain spending when budgets are stretched.⁴⁸ And that factor may be sufficient to sustain the Medicaid expansion over time.

48. In part, this reflects the fact that many states are required under constitutional mandates to balance their budgets. James M. Poterba, *Balanced Budget Rules and Fiscal Policy: Evidence from the States*, 48 NAT'L TAX J. 329, 330-31 (1995); Helen F. Ladd & Fred C. Doolittle, *Which Level of Government Should Assist the Poor?*, 35 NAT'L TAX J. 323, 329 (1982).

