ASPEN ECONOMIC STRATEGY GROUP

aspen institute

CHAPTER

Coverage Isn't Care: An Abundance Agenda for Medicaid

by Craig Garthwaite and Timothy Layton

Suggested Citation: Garthwaite, Craig, and Timothy Layton. 2025. "Coverage Isn't Care: An Abundance Agenda for Medicaid." In *Advancing America's Prosperity*, edited by Melissa S. Kearney and Luke Pardue. Washington, DC: Aspen Institute.

Coverage Isn't Care: An Abundance Agenda for Medicaid

AUTHORS

Craig Garthwaite* and Timothy Layton**

ABSTRACT

This paper provides a broad discussion of efforts to reform Medicaid not simply in size but also in its very construction, with a focus on maximizing the efficiency of this program. We begin with a high-level overview of the current structure of America's healthcare safety net for the poor and disabled, including Medicaid, noting that the piecemeal nature of Medicaid's evolution has created a complex program bringing together various populations, providers, operating models, and revenue streams. We then briefly examine implications of recently proposed reforms to this system, which largely hold the structure of the program fixed and focus on marginal changes to financing and eligibility. In the final part of the paper, we propose a broader and more fundamental set of reforms that acknowledge that Medicaid's contemporary size and scope require a different structure than those of its smaller historical predecessors. We propose policies that foster lower-cost-structure business models for safety-net healthcare providers in order to expand the number of these providers and more aggressively steer Medicaid patients to them. The goal is to use Medicaid's existing funding to provide easy access to basic healthcare services provided by a more abundant supply of safety-net healthcare facilities that work exclusively (or almost exclusively) with patients from this program.

* Herman Smith Research Professor in hospital and health services management and director of the Healthcare at Kellogg program, Northwestern Kellogg School of Management.

** Associate professor of public policy and economics, Frank Batten School of Leadership and Public Policy, University of Virginia.

Introduction

Medicaid has grown remarkably from a small, inexpensive program in the years following its introduction in 1965 into a major national health-insurance program, covering nearly one in four Americans. To place its size in perspective, Medicaid is now one of the largest public health-insurance programs in the world, enrolling more people than Medicare and more people than the public, social health-insurance programs of the United Kingdom, Germany, or France. Spending on Medicare in 2024 was still larger than Medicaid at nearly $1 trillion, but Medicaid was quite close, with nearly $880 billion in combined federal and state expenditures in that year (KFF n.d.b).

Unlike Medicare, which is a fully federally funded program that provides a uniform national health-insurance benefit to all elderly Americans, Medicaid is jointly financed by state and federal tax dollars while being designed and administered by each state. This setup leads to remarkable variation in the program's structure across the country. Perhaps more importantly, it means that the federal government's spending on the program is an incomplete metric of the funds necessary for access and coverage. The program's growth in size and scale means that it now comprises a substantial fraction of state budgets, with the average state spending almost one-third of its budget on Medicaid (Sigritz et al. 2024). Thus, while the program is jointly funded, states are extremely constrained in their ability to take on additional Medicaid costs, limiting their ability to fill in the gaps generated by any cuts to federal funding of the program.

"Medicaid's evolution from small, niche safety-net program to major national health insurer has been piecemeal."

Medicaid's evolution from small, niche safety-net program to major national health insurer has been piecemeal; it has expanded gradually from a program of categorical eligibility, restricted to specific low-income groups (such as pregnant women or the disabled), to—with the passing of the Affordable Care Act (ACA)—a broad-based entitlement for nearly all low-income adults. This growth has been coupled with a structural shift, with roughly 75 percent of beneficiaries now receiving care through private managed-care organizations rather than government-operated insurance programs. These firms include familiar names from other health insurance markets such as United, Aetna, Humana, and Centene, making the modern version of Medicaid quite different from the classic perception of a safety-net healthcare program run and operated by legions of government bureaucrats.

In its current form, Medicaid is vastly different from the plans of its original creators. The piecemeal nature of the various reforms and expansions has created a Frankenstein-like program bringing together various populations, providers,

operating models, and revenue streams. Much like Mary Shelley's eponymous character, the program today has remarkable strength in some ways but is otherwise unstable and largely misunderstood by all who encounter it. This state of affairs has meaningful effects on policy and on the debate about potential reforms.

At least some of this confusion and instability results from the diversity of populations covered through the program. The contemporary Medicaid population involves children, pregnant women, the disabled, dual-eligible seniors,[1] and those needing long-term care. Medicaid both pays for 41 percent of births in the US and is the largest single payer for long-term care services in the US. It is the nation's only true cradle-to-grave insurer. The medical requirements of these many different types of beneficiaries are meaningfully different, and it is therefore likely that the optimal insurance design differs, perhaps greatly, across these groups.

Despite this fact, the program largely takes a one-size-fits-all approach and attempts to provide a single comprehensive set of benefits to all enrollees. Unfortunately, this approach results in a series of square pegs jammed into round holes, with the basic design often trying to cater to various niche subgroups of enrollees (aged, blind, disabled, etc.) rather than to the group that now makes up the bulk of Medicaid enrollment: low-income Americans of all ages. Such a focus on niche subgroups rather than on the more mainstream Medicaid enrollee is not surprising given the history of the program. However, the program's shift toward providing coverage for large groups of mainstream low-income Americans likely necessitates a second, parallel shift: away from catering primarily to highly complex, specialized health problems and toward providing easy access to basic healthcare services (perhaps with carve-outs for these smaller, more complex groups).

Even with this complex and diverse population, Medicaid involves relatively little expenditure per enrollee.[2] Medicaid accomplishes this feat by paying very low rates to all medical providers. This frugality does not come without meaningful consequences for enrollees. Many providers simply refuse to accept Medicaid enrollees. Others consider treating these patients as a form of charity care. For example, many hospitals declare "underpayments" from Medicaid as part of their contribution to the public good. In recognition of these concerns, Medicaid directly funds some limited infrastructure through a series of additional payment streams to hospitals known as "provider-directed payments."

1 Dual eligibles are low-income seniors who qualify for coverage under both Medicaid and Medicare. For these individuals, Medicare is the primary insurer responsible for most medical costs while Medicaid provides coverage for cost-sharing payments and for services—such as long-term care—that are not covered by Medicare.

2 Given the variety of populations covered by Medicaid, simple comparisons of per-enrollee spending can be deceptive. However, several studies have examined risk-adjusted spending between Medicaid and commercial plans, documenting higher expenditures for those in the commercial market (Allen et al. 2021).

Taken together, Medicaid payments not only provide insurance for enrollees but also serve as a form of insurance for some facilities exposed to the costs of providing care for those without the financial means to fully pay for their services. However, as we discuss below, the size of these payments remains quite small, and their targeting is likely far from optimal. As a result, even in a world with Medicaid serving as an insurer for providers, many hospitals are hesitant to treat Medicaid patients. This hesitation increases as Medicaid recipients become a large fraction of the patient population. Compounding problems, payments to fund infrastructure and other fixed costs are generally not available to non-hospital providers—which are an important part of any definition of basic healthcare services.

Medicaid's multiple roles in the US healthcare system mean that it addresses important needs while leaving a wide array of actors in the system quite frustrated. This frustration often manifests as political controversy about the program's design and at times its very existence. The resulting debates largely focus solely on eligibility and spending levels—with little consideration of actual access or economic efficiency. Traditionally, Democrats have sought to expand eligibility and take-up of the program. In contrast, Republicans have typically attempted to limit the scope of eligibility expansions and ensure that those who receive Medicaid coverage are those they define as "truly" having the greatest need.

More recently, Medicaid's increasing electoral popularity and enrollment across numerous politically red states have shifted the debate. Republicans now focus less on *explicitly* paring back eligibility and more on decreasing *federal* spending on the program. This shift in focus is perhaps best exemplified by the recent budget bill debated extensively in the House and Senate and ultimately signed into law by President Trump. The bill includes no explicit cuts to eligibility for Medicaid, something that now appears to be a political nonstarter, but that as recently as during the previous Trump administration was a major goal of Republicans seeking to repeal the Affordable Care Act. Instead, the bill reduces Medicaid expenditures by cutting enrollment largely via more opaque administrative burdens and work requirements, plus other opaque funding cuts unrelated to enrollment and intended to shift costs away from the federal government and onto states. Such reductions in federal support are meaningful, as they leave policymakers in states, which have a requirement to balance their budgets, to decide whether to fill the funding gap via increased state expenditures or to instead reduce spending. Of course, the tools available to state policymakers for lower spending largely include those traditionally discussed at the federal level, namely, limiting eligibility and enrollment. But, at least at the federal level, the politics of Medicaid have changed to a point where both parties see value in the program but one party wishes for it to take up a smaller share of the federal budget.

In this paper, we thus move beyond the typical debates over Medicaid's size and cost to examine its very construction, focusing on reforms that could maximize the value of its substantial expenditures, a goal that both parties should be able to agree on. We begin by providing the essential economic and historical context of the healthcare safety net, explaining how Medicaid evolved into its complex current form. We then analyze the fundamental limitations of recent reform proposals, which largely focus on relatively marginal changes to eligibility and financing without addressing the program's core structural flaws. In the final section, we outline a more fundamental reform agenda. We argue that policymakers interested in a truly effective safety net operating at the scale of today's Medicaid program must go beyond the standard focus on subsidizing demand for healthcare services and begin to pay attention to the supply of these services to Medicaid patients. We outline a vision for how this type of supply-side effort could make the program deliver more for enrollees without costing taxpayers any more than it already does.

This effort should begin by explicitly acknowledging the existence of an implicit two-tiered system whereby Medicaid beneficiaries have coverage but lack access to high-quality medical care. Productive reforms should focus on a redesigned program that fosters an abundant supply of providers of basic care for the Medicaid tier. Our proposal focuses on targeted regulatory relief and the integration of new artificial-intelligence technologies (AI) to create lower-cost, sustainable business models for providers who primarily serve Medicaid patients, with the goal of ensuring abundant access to basic care. While some might argue that these types of reforms provide a lower standard of care for low-income Americans and confine them to lower-quality healthcare services, we emphasize that the goal is not to diminish the quality of care received by Medicaid enrollees. Instead, our proposals aim to help the large number of Medicaid patients who currently have access to no care (or very limited care) under the current system to have easy and abundant access to (at least) basic healthcare services.

1. The economic rationale for a healthcare safety net and the history of Medicaid

In the United States, Medicaid serves as the largest funding source among a variety of programs and initiatives that comprise a safety net or social-insurance system for healthcare. In considering the optimality of such a system, it is important to be clear about the economic rationale for its existence. From an economic perspective, the primary purpose of social insurance is to provide resources to individuals for whom particularly bad states of the world have been realized and for whom market-based coverage is not available. While the decision to provide social insurance can be driven by many factors, in healthcare a primary motivation is a broadly held

social concern about equity in and access to specific services. The existence of this social concern for equity can be seen across a range of policies where healthcare receives special consideration.[3]

It should not be surprising that an optimal healthcare safety net provides the most benefit to those who (1) are poor and (2) are sick (or could potentially become sick). In some sense, these beneficiaries have simultaneously been hit with two negative shocks, one affecting their income and the other affecting their health. Because negative health shocks come with expensive treatments, the health shock can be thought of as a reduction in the household budget, akin to the consequences of the negative income shock. These beneficiaries are thus in a precarious financial situation, and a safety-net healthcare program can provide them with important insurance value by offering resources when they are needed most.

Ideally, the government could simply provide cash transfers to these individuals, but this approach is not feasible. There is tremendous ex ante uncertainty about how much money would be required to make a person "whole" after a health shock, especially given the rapid pace of technological change in medicine. Furthermore, conditioning financial aid on a specific diagnosis would create incentives for such conditions to be overdiagnosed.[4] For these reasons, healthcare safety-net programs generally operate via in-kind transfers, providing medical care at little or no cost to beneficiaries.[5] This method still meets the core insurance goal, as beneficiaries with the greatest medical needs receive the most resources.

In addition to providing insurance, these in-kind transfers also stimulate demand for healthcare services, which can be economically efficient for several reasons. While economists once viewed the additional consumption spurred by insurance as inefficient "moral hazard," a more recent view recognizes that individuals often under-consume healthcare (Baicker et al. 2015; Chandra et al. 2021). This under-consumption occurs because patients may not fully recognize or internalize the value of certain services (particularly preventive care), and because high prices and liquidity constraints can prevent them from accessing even cost-effective treatments (Besanko et al. 2020). These factors are especially pronounced for low-

3 For example, the Emergency Medical Treatment and Active Labor Act (EMTALA) requires that all hospitals that accept Medicare and have an emergency room must provide treatment to patients in emergent conditions without considering the ability of the patient to pay for such services. This law was driven in part by a practice of "patient dumping," where critically ill patients were denied care at one hospital and transferred to another to receive treatment.

4 Potential concerns also arise about incentives for innovation if lump-sum payments represent the cost of today's level of care and not the potential benefits from treatments that have not yet been developed.

5 This use of in-kind transfers is also a feature of commercial health-insurance markets—which suffer from many of the problems described above. An important difference is in the financing and costs of the program. Commercial health insurance is financed through premiums from enrollees that are paid through a mixture of direct payments and foregone wages. In addition, commercial health insurance involves additional cost-sharing payments.

income individuals. Subsidizing healthcare for this group can therefore correct for this under-consumption and increase demand toward a more efficient level.[6] Further, in the absence of a healthcare safety net, low-income individuals still receive care; hospitals and providers are simply often not compensated for providing it. This uncompensated cost can be seen as a negative externality imposed on providers or on paying customers—who may have a more difficult time finding healthcare providers because the fixed costs of operating a hospital (which include treating the uninsured) are higher, potentially leading to fewer hospitals. This type of negative externality can provide an additional rationale for the government stepping in and explicitly subsidizing medical care for this group via a healthcare safety net.

An important distinction here (relative to other sectors of the economy) is that the provision of medical care often involves economically meaningful fixed costs rather than simply variable costs that can more easily be subsidized on the margin. Clinics and hospitals are integral parts of a healthcare safety net, and they often require large, fixed, up-front investments to provide the services beneficiaries need. The size and nature of these investments can impact the quality of care across a variety of dimensions (Garthwaite et al. 2022). This distinction is particularly important when services are provided at facilities that treat enrollees both from the healthcare safety net and the broader commercial market—two populations that may demand different levels of quality and compositions of services and that come with different levels of resources to finance these services.

The importance of the distinction grows when you consider that the quality created by these fixed costs is difficult to tailor to specific patients within a facility. This consideration brings up two potential concerns. First, the quality demanded by patients in the commercial market may exceed the level necessary to meet society's definition of basic equitable access (which the healthcare safety net is meant to provide). Second, optimal healthcare for low-income patients may require a very different type of infrastructure than other patients, especially when it comes to the location of that infrastructure. At given spending levels, facilities may not find it attractive to make the necessary investments for low-income patients (such as facilities in low-income neighborhoods) when they could simply profitably serve commercial patients. This problem is exacerbated by the limited supply of physicians, the only individuals legally allowed to directly provide medical care or, in some cases, supervise the provision of medical care by other (lower-cost) types of providers with less extensive and specialized training.

6 It should be noted that there are limits to the extent of this theory both in magnitude and type of service. Not all services are under-consumed when unsubsidized, and the complete subsidy provided by the current system could lead to the overconsumption of some services.

Both these factors imply that an optimal healthcare safety net cannot simply focus on subsidizing demand for healthcare but must also seriously contend more directly with supply. Doing so could involve fixed-cost investments in facilities for Medicaid populations; such a recognition also implies that an efficient healthcare safety net may involve investments specific to facilities for low-income patients, such as true safety-net hospitals and community health centers and other healthcare providers that (almost) exclusively treat Medicaid patients. We note that these facilities have long had a role in the broader healthcare safety net. However, discussions about these facilities are largely separate from policy discussions of the optimal size and scope of Medicaid. We argue that the development of an abundant supply of providers targeted to Medicaid patients (both in location and in cost structure and quality) should be a key component of any true Medicaid reform. Such development likely requires a more direct subsidization of supply (beyond existing direct-provider payments), which could result in a more efficient healthcare safety net that does more with the same level of funding.

1.1 The History of Medicaid

Lyndon Johnson's "War on Poverty" included two sets of policies that are the basis of today's safety net: The creation of Medicaid, and the opening of the first Community Health Center (CHC). In many ways, these two policies represent markedly different yet potentially complementary policies to address the provision of healthcare to low-income Americans. Despite the potential for independent and complementary effects, for a variety of political and practical reasons the policy discussion has largely focused on the former over the latter. This focus is perhaps understandable: Providing insurance for patients to access the current system certainly means less direct government involvement in the provision of services and a greater reliance on the private market. This policy route has long been preferred—though it suffers from the fact that markets focus more on efficiency than equity. In addition, the primary beneficiaries of Medicaid and its subsequent expansions have been incumbent medical providers—which have long been a powerful political lobby. In contrast, developing new infrastructure (like CHCs) primarily for safety-net beneficiaries provides more of an appearance of a government takeover of the healthcare system and also potentially introduces more competitors for the politically powerful incumbents.

Medicaid was created in 1965 as a voluntary program, where states could choose to participate or not, but choosing to participate meant complying with federal program requirements related to eligibility, benefits, and so forth. At the time of its enactment, Medicaid was a relatively small program, and eligibility was generally tied

to eligibility for cash assistance programs, namely Aid to Families with Dependent Children (AFDC, now TANF) and the Supplemental Security Income (SSI) program (Rudowitz et al. 2024).

The enrollment requirements of these programs were often highly restrictive and required unemployment or incapacitation of parents in a household or incapacitation of individual beneficiaries. Therefore, this linkage restricted enrollment in the program to two "categorically needy" groups: the aged, blind, and disabled (SSI) population and very-low-income families with dependent children. Outside these groups, states were also allowed to provide Medicaid to "medically needy" parents and children with higher incomes but with very high medical expenses (Paradise et al. 2015). Thus, the original set of Medicaid enrollees were those who had experienced either extreme labor-market shocks, resulting in exceptionally low incomes, or those with moderate labor-market shocks plus major health shocks, leading to low incomes and high healthcare costs.

The highly restrictive eligibility rules initially kept the program quite small (even after all states were participating), with enrollment holding steady around 20 million through around 1990 and spending generally falling below $50 billion (in 2020 dollars) through the same date (MACPAC n.d.a.). The small size and highly restrictive nature of the program likely reflected society's views at the time about who should gain access to indigent care: that is, only the "truly" needy.

When setting up Medicaid, policymakers faced a few options for structuring the funding and design of the program. Perhaps most obviously, they could have chosen to structure the program similar to the Medicare program they were contemporaneously creating—that is, it would be designed, funded, and operated at the federal level. Alternatively, they could have completely delegated the program to the states through a grant-based program where states were allocated a fixed amount per enrollee and then left to decide the best way to spend those dollars (potentially conditional on meeting certain federal requirements). Third, the federal government could provide matching funds for every dollar of state funding but allow the states relatively broad latitude as to the breadth and scale of the program.

This third option was selected for a variety of reasons. A primary nonpolitical motivation was an attempt to generate a balance between incentives to develop a broader safety net while also maintaining pressure to limit growth. It was clear from the revealed preferences of state policymakers that without some additional incentives many states would not provide (or at least would under-provide) access to indigent care. This state of affairs suggested a clear role for new federal spending to support the safety net.

However, a new and entirely federal program faced pushback on several dimensions. The first was a practical problem: Such an effort would at least partially replace successful programs already operated and financed by a number of states. A more philosophical reason was a justifiable concern that a federal program faced the risk of less controlled and rising spending because of limited incentives to balance the federal budget. States, on the other hand, generally must balance their budgets every year. This obligation forces policymakers to weigh the benefits of providing a large enough safety net against the necessity of keeping taxes low in order to attract residents and firms to the area. Given that the populations served by safety net programs typically have limited political power (a trend that was especially true for early Medicaid enrollees, given their demographics), states had much to gain by keeping safety net spending and taxes low and little to gain from allowing overly generous programs. For this reason, state-financed safety net programs have long exhibited more fiscal discipline than federal programs.

Therefore, a financing scheme where the federal government matches state spending had the potential to provide the appropriate incentives for a "Goldilocks" safety net that was neither too stingy nor too generous. It also had potential to provide each state with the flexibility to design a program addressing its specific needs. Such flexibility was believed to be particularly important for a safety net program because the specific reasons why people need safety net care and the type of care they require can vary greatly in a country that is as geographically and economically as diverse as America.

As is the case with many great theories, the economic reality turned out to be a bit different than predicted. Unlimited matching funds, even when they require states to put in some money of their own, can encourage state legislators to engage in wasteful spending in order to bring more federal dollars into their economies. The incentives here are a function of the size of the match rate (with larger federal rates weakening incentives for states to restrain spending) and whether there are ways for states to game the matching payments to ramp up federal contributions while limiting state expenditures. At different time periods, Medicaid has offered conditions for states to structure programs to extract federal revenue. State lawmakers have proven particularly adept at identifying opportunities to game this structure.

The match rate for each state was determined by a formula called the Federal Medical Assistance Percentage (FMAP). FMAPs were a function of the state's per-capita income relative to the national per-capita income, with a lower bound of a 1:1 federal-to-state match (50 percent FMAP) and an upper bound of an almost 5:1 federal-to-state match. Thus, states with the lowest incomes received very generous federal matching funds and required relatively little state investment to run their programs.

Despite these relatively generous matching payments, states still generally sought to keep Medicaid spending low. They did so partially because healthcare costs were growing rapidly, and even with generous matching rates, Medicaid spending quickly started eating up a substantial share of state budgets. Three tools are generally available to limit spending in an insurance program: limiting enrollment, limiting covered services, or paying providers low rates for services.

The federal government has generally been fairly strict about dictating the set of required covered services, leaving little room for states to refuse coverage for specific types of medical care. States were therefore left with the options of either limiting enrollment or paying providers low rates. States generally opted for both strategies, with some differentiation between "blue" states, which tended to provide generous eligibility criteria and very low provider payment rates, and "red" states, which tended to provide highly restricted eligibility criteria and modestly higher provider-payment rates. But overall, Medicaid payment rates have always been quite low, far below commercial rates and even below Medicare rates.

The story for pharmaceuticals is largely similar but is more uniform across the country. In the beginning, Medicaid generally paid typical prices for drugs, not necessarily receiving much of a discount relative to other payers. But, as with provider payments, eventually prices for drugs were targeted as a source of Medicaid savings. In 1990, the Medicaid Drug Rebate Program was initiated, which made drugs like other services by (1) offering state Medicaid programs the "best price" offered by a drug manufacturer to any commercial insurers in the market[7] and (2) simultaneously requiring states participating in the rebate program to cover all drugs approved by the FDA. While limits on the breadth of coverage in terms of drug types were generally not allowed, quantity limits (such as prescription drug caps) were widely used to further ration access and limit costs (Layton et al. 2022).

Ultimately, all these regulations and design choices resulted in a Medicaid program that varied widely based on state preferences for overall funding and based on the distribution of that funding between generous eligibility versus generous (or, more accurately, not-as-stingy) provider payments. In all states, however, patients' medical-care consumption was generally fully subsidized from the point of view of the patient, as required by federal rules, and spending was kept in check via the restrictions on the supply side, either via explicit quantity limits, or, more often, through paying low provider-payment rates and relying on the upward-sloping supply curves of providers.

7 Technically, states got either the lowest price paid by any commercial entity or a flat discount off the list price—whichever was lower.

Medicaid enrollees are thus generally fully covered for pretty much anything the healthcare system provides, as long as they can find someone willing to treat them. This last caveat has been a growing problem for enrollees.

One place that Medicaid enrollees (and the uninsured) have always been able to get care is Community Health Centers, now known as Federally Qualified Health Centers (FQHCs). Created in 1965 along with Medicaid, these facilities represent an alternative approach to building a healthcare safety net, providing a range of primary-care and social-support services directly to low-income patients rather than just subsidizing access to existing mainstream medical facilities like Medicaid does. In many ways, this alternative approach has been highly successful but remains largely overlooked by policymakers. Following expansions in the 1970s that brought centers to hundreds of mostly rural counties and additional funding through the ACA, FQHCs have proven to be a cost-effective model for care (Bailey and Goodman-Bacon 2015). Research shows that FQHCs provide high-quality basic care more efficiently than other settings do—with their patients having fewer specialist visits and lower rates of hospital admission—and that their initial rollout led to meaningful reductions in mortality (Nocon et al. 2016; Bailey and Goodman-Bacon 2015). Despite this record of success, FQHCs remain a secondary component of the healthcare safety net; the majority of Medicaid spending continues to flow to higher-cost care settings, demonstrating how the system has consistently prioritized subsidizing demand over directly building supply, but also providing motivation for our proposal to experiment more with supply-side policy.

1.2 Growth of Medicaid

Between its enactment in 1965 and today, Medicaid has evolved substantially. The most salient piece of that evolution is its growth. Take-up of the program by states was fairly rapid after enactment. Most of the growth was instead driven by expanded eligibility rules. Figure 1 shows that in the initial two decades after enactment, enrollment was steady at around 20 million, despite steady population growth during that period.

1.2.1 History of enrollment growth

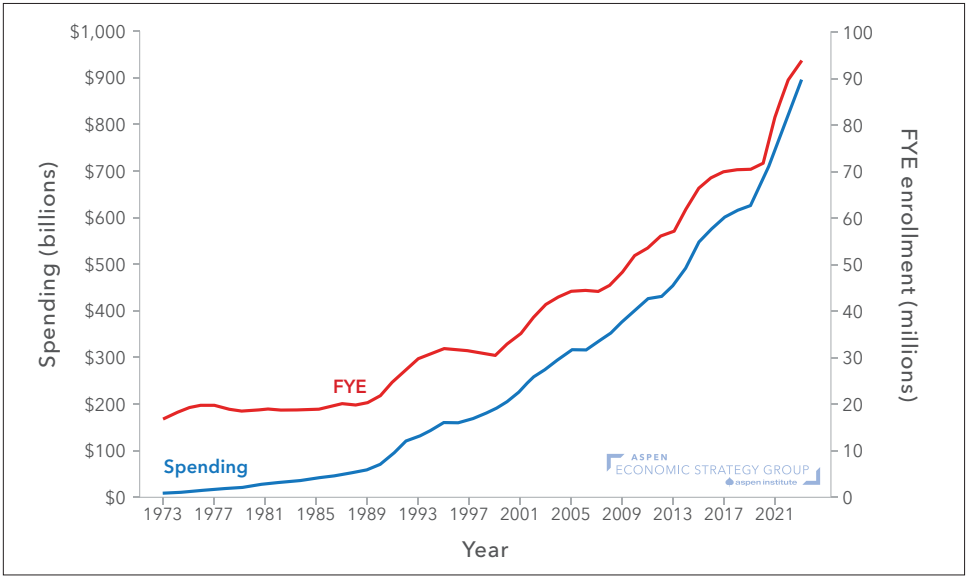
Enrollment growth began in the early 1990s and was led by eligibility expansions for higher-income (but still quite poor) pregnant women and children. Concerns about high infant mortality rates led Congress to seek ways to improve access to care for these groups. In the late 1980s and early 1990s, the federal government required states to cover pregnant women and children under 6 with incomes up

to 133 percent of the federal poverty line (FPL) and school-age children (age 6-18) up to 100 percent of the FPL (Paradise et al. 2015). Combined with other policies, this requirement made Medicaid an entitlement for all low-income children and pregnant women across the country.

In 1997, further expansion took place via the introduction of the State Children's Health Insurance Program (CHIP), which was separate from Medicaid but very closely linked. CHIP expanded coverage by providing generous federal matching payments (higher than the typical match rate) to states that chose to expand coverage to children with incomes above the national Medicaid eligibility levels. Because the federal matching payments were so generous, many states expanded eligibility to children with incomes much higher than 100 percent of the FPL, with many states setting eligibility around 200 percent of the FPL. This expansion led to substantial enrollment growth throughout the first decade of the 2000s. Today, CHIP income limits are as high as 405 percent of the FPL in New York and as low as 190 percent in Idaho (Peter G. Peterson Foundation 2024).

After the CHIP expansions, policymakers intent on bringing down the stubbornly high uninsurance rate (generally ranging from 16 to 18 percent throughout the 1990s and the first decade of the 2000s) homed in on low-income adults as the last group of low-income individuals ineligible for Medicaid coverage (CDC 2024), ultimately leading to the most recent Medicaid expansions as part of the Affordable Care Act of 2010. While the ACA used a combination of public (Medicaid) and subsidized private (ACA Marketplaces) coverage to bring down the uninsurance rate, Medicaid expansions were significant, making all adults (with or without children) with incomes below 138 percent of the FPL eligible for the program.

Figure 1: Medicaid enrollment and spending, 1970–2020



Notes: FY is fiscal year. FYE is full-year equivalent, which also may be referred to as average monthly enrollment. All numbers exclude CHIP-financed coverage. Data prior to FY 1977 have been adjusted to the current federal fiscal-year basis (October 1 to September 30). The amounts shown in this exhibit may differ from those published elsewhere due to slight differences in the timing of data and the treatment of certain adjustments. The amounts may also differ from prior versions of MACStats due to changes in methodology by the CMS Office of the Actuary (OACT). Spending consists of federal and state Medicaid expenditures for benefits and administration, excluding the Vaccines for Children program. Enrollment counts are FYEs and, for fiscal years prior to FY 1990, have been estimated from counts of persons served (see MACPAC's "Technical Guide to MACStats," Macpac.gov, 2025, https://www.macpac.gov/macstats/data-sources-and-methods/ for a discussion of how enrollees are counted). Enrollment data for FYs 2013–2020 are projected. Enrollment for FYs 1999–2020 include estimates for the territories.

Source: MACPAC 2015

Initially, the ACA Medicaid expansion was designed to be mandatory. To lessen the impact on state budgets, it was paired with a perpetual 90 percent federal matching rate. However, the Supreme Court ruled in 2012 that the federal government could not make expansion mandatory, creating an option for states to adopt (or not) the expansion (Perkins 2013). Nevertheless, given the high federal matching payments, most states took up the option to expand initially, and many of the remaining states have slowly trickled into expansion as well, either via legislative action or, in some cases, via popular referenda.[8]

Thus, outside the states that have not expanded, the program has become an entitlement for all low-income Americans, not just for pregnant women, children,

8 As of the writing of this paper, ten states have not adopted the ACA Medicaid expansion. They are Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming.

and the disabled, ending categorical eligibility for good. These expansions resulted in Medicaid enrollment surpassing 70 million for the first time in 2019, more than triple its original enrollment of around 20 million during the first decades of the program.[9] In more recent years, enrollment had by December 2024 reached a steady state of around 78.5 million, or almost one-fourth of the US population (KFF 2025).[10]

1.2.2 History of spending growth

During its initial decades, Medicaid was a relatively inexpensive program, with spending remaining below $25 billion until the mid-1980s and below $100 billion until the early 1990s. Spending then took off throughout the 1990s and has continued to grow rapidly up to the present. Spending has also grown as a share of federal outlays, starting at around 1.4 percent in 1970 and reaching almost 10 percent by 2015. This rapid growth in spending corresponds to equally rapid growth in enrollment, but enrollment growth isn't the entire story of spending growth in the program.

In his history of Medicaid spending, John Klemm (2000) divides the pre-2000 period into eight "eras" of spending growth. These eras and their effects can provide insight into current reform efforts—many of which match at least one historical effort. Some of the eras correspond to times of eligibility expansion, but others correspond to increases in medical inflation and other changes in the Medicaid program.

One of the "eras" of particular interest to this paper was the "retrenchment" era from 1982 to 1984. What at that time appeared to be rapid growth in Medicaid costs led to efforts to slow Medicaid spending. A primary effort to cut spending consisted of the federal government reducing federal matching payments for states with high growth rates. Simultaneously, states were granted important new flexibilities in program design to allow them to adjust to funding cuts in ways that matched their local conditions. This era was the beginning of state experimentation with Medicaid managed care, where states would pay a fixed capitation rate to a health maintenance organization (HMO) to provide Medicaid benefits to enrollees. It was also the beginning of home-and-community-based service (HCBS) waivers that would allow states to provide home-based care in an attempt to keep enrollees out of expensive nursing homes. Both managed care and HCBS would go on to play major roles in the Medicaid program for decades to come.

9 While the ACA also expanded coverage via other routes, estimates suggest that the majority of the increase in insurance take-up came via Medicaid, though around half the increase attributed to Medicaid is estimated to have come from "woodwork" effects of enrolling individuals who were actually eligible for the program prior to expansion but were not enrolled.

10 During the pandemic, enrollment was even higher, reaching over 90 million in June 2023. However, much of this growth was driven by suspensions to eligibility redeterminations during the pandemic (eligibility is typically determined annually, but during this period there were no redeterminations).

1.2.3 Medicaid's first forays into supporting healthcare supply

Another important era of spending growth unrelated to enrollment was what Klemm refers to as the "Taxes and Donations and DSH" era. During the 1980s, Medicaid introduced a new feature of the program: Disproportionate Share, or DSH, payments. These payments were made directly to hospitals that bore a greater burden from serving low-income patients (Applied Policy 2024). Unlike traditional Medicaid payments, DSH payments were not tied to specific services provided and were therefore more similar to lump-sum transfers that covered the fixed costs of being a safety net provider. Ostensibly these payments were meant to subsidize the provision of uncompensated care, but they also were intended to "make hospitals whole" for treating large numbers of Medicaid patients, for whom fee-for-service payment rates were often seen as falling below the *average* cost of providing care. For hospitals with greater exposure to Medicaid, the average cost of treating these patients is a bigger economic long-run consideration for ongoing operations and strategic decisions.

DSH payments were Medicaid's first shift away from purely subsidizing demand for healthcare and into the business of subsidizing the *supply* of safety net healthcare. However, these payments also inadvertently opened a new door through which states could develop schemes to extract additional federal dollars to fund their Medicaid programs. First, states could allocate larger DSH payments to hospitals, which would formulaically trigger increased federal matching payments. The state could then recoup these new federal dollars from the hospitals via provider taxes and "donations" from the hospitals to the state. If states didn't claw back all the additional federal dollars, such schemes could leave both hospitals and the state better off, although federal taxpayers in other states were obviously left footing the bill.

Such systems were often appropriately derided as "shenanigans" and were largely responsible for increasing DSH expenditures from $1 billion in 1990 to more than $17 billion in 1992 (Baicker and Staiger 2005). This sum constituted about 15 percent of total Medicaid medical assistance expenditures in that year. Given the abuse of these programs, estimates of the health effects of the DSH program varied across settings. When these payments actually remained with hospitals, they reduced mortality. However, when the federal payments were expropriated by states, they had no effect on mortality (Baicker and Staiger 2005).

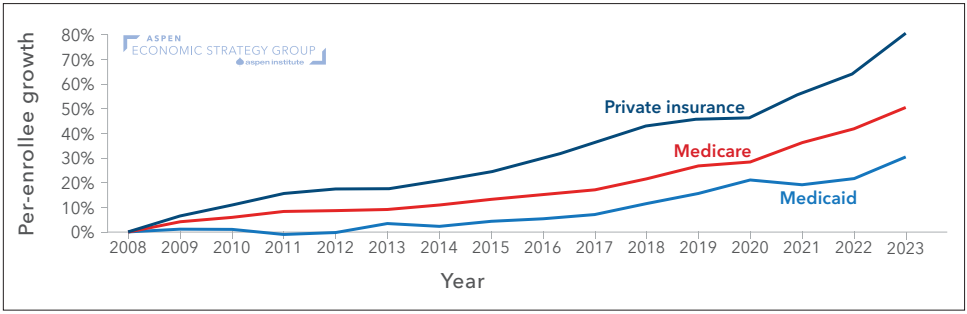
Over time, the federal government placed limits on DSH spending to try to combat these schemes, limiting total state DSH payments to 12 percent of that state's total Medicaid expenditures (Mitchell 2023). With the implementation of these limits, DSH payments as a percentage of spending have declined substantially over time, making up only 2 percent of total Medicaid expenditures in 2022 (Applied Policy

2024). This outcome has shifted Medicaid once again away from subsidizing supply and back toward primarily subsidizing demand.

The decline of the role of DSH payments as a subsidy for facilities has not limited states' fiscal shenanigans. Instead, states have simply shifted toward using provider taxes as the mechanism. Under these schemes, states raise rates paid to providers in order to extract additional matching funds from the federal government—but they then tax those providers to bring those additional federal dollars into state coffers, without the need for the state to contribute any of its own funds. In more recent years, this tactic has been expanded to also include managed-care taxes. Higher FMAPs for new coverage populations can also be used to extract additional federal dollars, by shifting as many enrollees as possible out of traditional eligibility categories and into new categories with higher match rates.

Such efforts at extracting greater federal support are perhaps not surprising. Medicaid has largely enjoyed slower per-enrollee growth than all other healthcare programs (figure 2). That said, despite this slower growth, each year the fraction of the state budget captured by Medicaid increases. In the early decades of the program, Medicaid accounted for less than 10 percent of state spending. By the early years of the first decade of the 2000s, it had grown to almost 20 percent. Today, Medicaid accounts for almost 30 percent of total state expenditures, making it the single largest spending category in most states, finally surpassing K–12 education spending (Sigritz et al. 2024). Medicaid thus looms large for state policymakers. Policymakers may thus also have limited options for adjusting to a shift of federal financial responsibility to the state level.

Figure 2: Per-enrollee growth by insurance type, 2008-2023



Source: McGough et al. 2024

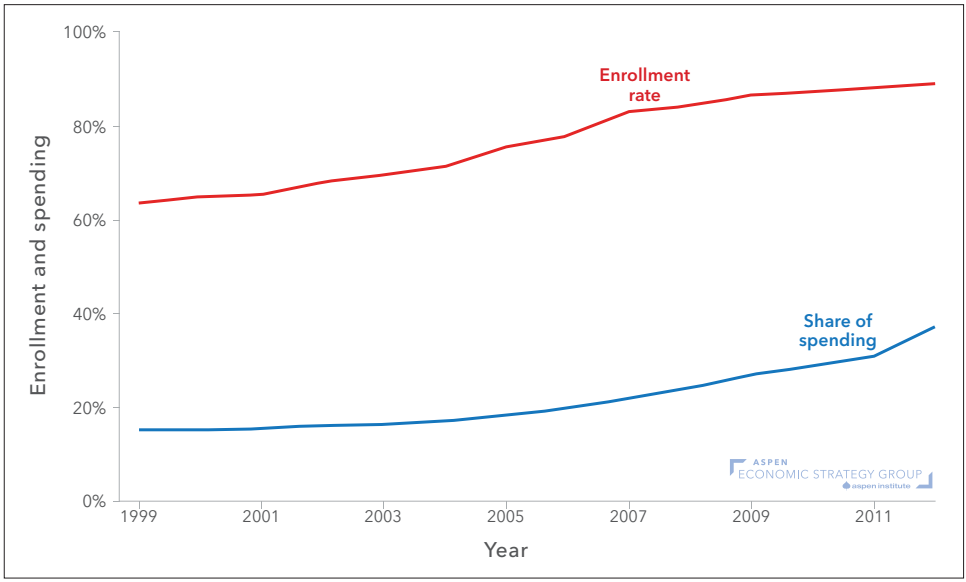
1.2.4 Medicaid managed care (MMC)

As discussed briefly above, a major change in Medicaid occurred in the 1980s when states were given the flexibility to experiment with providing Medicaid via private managed-care plans (HMOs). Under this model, states could pay a single "capitated" per-person per-month (PMPM) fee to a private managed-care plan, and that managed-care plan would then be responsible for providing all medical services to those enrollees. The important economic incentives of these contracts stem from the fact that a managed-care plan can retain any savings they achieved below the PMPM rate but must also "eat" any losses from spending above that rate.

States like California and Arizona adopted managed care relatively early, in the 1970s and 1980s, but adoption really took off around the country in the 1990s. At that time, the federal government allowed states to adopt MMC statewide (rather than only locally), allowed states to require subgroups of Medicaid beneficiaries to enroll in MCOs, and allowed insurers to have Medicaid-specific plans (Bradford and Costanza 2023). These changes, along with a more general shift to managed care across other segments of the health insurance market, led to rapid growth in MMC penetration during the 1990s. In 1991, MMC penetration was just under 10 percent. By 1998, penetration surpassed 50 percent.

While the rest of the country faced a managed-care backlash in the late 1990s, no such backlash occurred in Medicaid. Instead, Medicaid managed care continued to grow. In a 2018 report, the Congressional Budget Office estimated that managed-care penetration grew from 63 percent in 1999 to 89 percent in 2012, though not all the individuals they counted were enrolled in *comprehensive* managed-care plans (Burns and Layton 2018).

Figure 3: Medicaid managed-care enrollment and spending, as a percentage of total Medicaid enrollment and spending, 1999–2012



Source: Burns and Layton 2018; data from Congressional Budget Office and the Centers for Medicare and Medicaid Services Analytic extracts for 1999 to 2012.

Importantly, however, the same CBO report points out that the percentage of Medicaid spending going to managed care remained quite low relative to the level of managed care enrollment (see figure 3). In 1999, MMC accounted for just 15 percent of Medicaid spending, versus over 60 percent of enrollment. This number ticked up somewhat by 2012, reaching 37 percent by that year, but its share of spending was still significantly below its share of enrollment of 89 percent at that time (Burns and Layton 2018). This low spending level was largely due to the fact that the initial growth of MMC was concentrated almost entirely among young, relatively healthy populations—children and pregnant women. Sicker, more expensive populations, such as the elderly and disabled, were initially carved out of MMC due to concerns that private plans might stint on care for these populations. As these populations made up most of the spending in Medicaid, MMC plans only received a relatively small share of Medicaid dollars for some time. More recently, however, this disconnect between managed care's share of enrollment and its share of spending has begun to change, with states increasingly enrolling disabled populations into MMC, starting managed long-term care programs, and experimenting with comprehensive private managed-care plans for dual eligibles that provide both Medicaid and Medicare services.

1.2.5 Contract structure and the market for Medicaid MCOs

A state's choice to use Medicaid managed care (MMC) is ultimately a decision to outsource the provision of social insurance, with the goal of leveraging private firms to control spending and improve care coordination. The structure of this outsourcing relationship, however, is complex. States typically contract with multiple managed-care organizations (MCOs) for three- to five-year periods, but capitation payments are set administratively rather than through competitive bidding. Federal rules require these payments to be "actuarially fair," meaning they are based on projections of past spending. This requirement creates a dynamic-incentive problem: If an MCO reduces costs today, it will likely receive lower payments tomorrow, limiting its willingness to make significant investments in efficiency. This market has also evolved significantly. Initially populated by local nonprofit plans, the MMC landscape is now increasingly dominated by large, national for-profit insurers, such as Centene, which have grown by acquiring smaller, local plans (Li and Layton 2025).

The MMC program has thus not only expanded significantly since its inception, but it has also become much more commercialized. While MCOs started and owned by local safety-net hospitals still play a major role in Medicaid, making up just under 20 percent of MMC enrollment throughout the first two decades of the 2000s, and while MCOs still differentiate this health insurance market from others, every year the Medicaid market looks more and more like commercial markets, with large, national for-profit insurers (now, often with presence in the individual and Medicare Advantage markets) increasingly competing for, and winning, state contracts (Li and Layton 2025).

1.2.6 Effects of the shift to managed care on program finances and enrollee health

The motivations for states to shift to managed care are complex, extending beyond simple cost savings. States value the greater budget predictability that comes from outsourcing risk to private plans, which is particularly important for states with balanced-budget requirements, though in practice states often retain significant risk by carving out the sickest populations (Perez 2018). States also turn to MCOs for improved care management and coordination, as private plans can provide established provider networks and care management tools that state-run programs often lack the capacity or expertise to develop. Finally, MCOs are often perceived as being more efficient and possessing greater freedom to innovate in care delivery than state bureaucracies, a belief that can make increased Medicaid funding more politically palatable and allow for benefit expansions that might not otherwise occur (Layton et al. 2019).

Ultimately, however, the evidence on the actual effects of managed care on program costs and beneficiary health is fairly mixed. With respect to program costs, there is little evidence that managed care saves states (or the federal government) money; early work indicated that initial shifts to managed care led to higher spending (Duggan and Hayford 2013), and more recent work has produced similar findings (Layton and Politzer 2024). Evidence also indicates little effect of managed care on budget predictability (Perez 2018). Estimates of effects on access to care have also been mixed, with studies finding that managed care improves access in some cases, reduces it in others, and has little effect in still other instances (Layton et al. 2019; Sparer 2012; Montoya et al. 2020). Recent work leveraging random assignment of beneficiaries, however, sheds some light on these questions. This work indicates that managed care does reduce spending on healthcare—with savings coming from pharmacy utilization management and lower prices for outpatient services—but these cost reductions were modest and appeared to come at the cost of quality and consumer satisfaction (Agafiev Macambira et al. 2022). Further evidence from random assignment to different *managed-care plans* indicates that all plans are not created equal, with spending differing by more than 20 percent from one plan to another; again, lower spending comes largely via rationing and at the cost of patient satisfaction (Geruso et al. 2023). These results provide some insight into why overall findings are so mixed: Not only do state MMC programs differ substantially, but important variation also exists even within programs across plans.

In the end, the effects of MMC are thus unclear and vary substantially across settings; existing evidence provides little guidance as to the wisdom of shifting enrollments to MMCs. We know that doing so does not seem to lower program costs on average, so if cost reduction is the primary motivation, the strategy is probably going to disappoint. But it may lower healthcare costs and limit low-value care, and it could improve access for beneficiaries, at least under certain circumstances. But, in the end, states have shown via revealed preference that they like managed care better than the alternative, and it is thus likely here to stay as a key component of the Medicaid program.

2. Medicaid at 60: Who and what does Medicaid cover today? How might that change?

As described above, Medicaid today looks very different than Medicaid of the early years. This is true across many dimensions that impact optimal program design.

2.1 Enrollment and spending

Today's Medicaid is almost a tale of two programs based on whether you are discussing enrollment or spending. For example, the largest enrollment group is

children, who make up nearly 40 percent of all enrollees. However, kids are relatively inexpensive and account for only 16 percent of spending (Baumrucker et al. 2025). Similarly, while expansion and non-expansion adults respectively account for 23 percent and 16 percent of enrollment, they are only responsible for 11 percent and 19 percent of spending. In contrast, individuals with disabilities and the elderly are responsible for much more spending than their enrollment shares would predict. Individuals with disabilities make up only 12 percent of enrollees but account for a full 33 percent of spending. The elderly make up 10 percent of enrollees but account for a full 22 percent of spending. Even this number is deceptive, as the vast majority of individuals in this group also have Medicare coverage for most standard healthcare services, meaning that they account for this large share of Medicaid spending even though Medicaid only covers a sliver of their healthcare costs.

Another way to consider Medicaid's role in the healthcare economy is to ask how much particular demographic groups depend on it. This perspective could be important as these groups require different investments in supply. For example, only 16 percent of all non-elderly adults are enrolled in the program compared to 39 percent of children. Medicaid pays for more than 40 percent of all births and provides insurance for 44 percent of non-elderly individuals with disabilities. Medicaid covers only 16 percent of white Americans but 35 percent of Black Americans and 40 percent of American Indians/Alaska Natives. Perhaps one of the most important groups of Medicaid enrollees is nursing-home residents, of whom Medicaid covers over 60 percent. Indeed, while only around 5 percent of Medicaid enrollees use long-term services and supports (LTSS), those individuals accounted for almost 30 percent of Medicaid spending. These figures demonstrate Medicaid's outsize role affecting strategies of firms providing long-term care.

Medicaid's importance also varies significantly across states—a point that may have meaningful implications for the politics of Medicaid reform. For example, over 30 percent of individuals in Louisiana and New Mexico are enrolled in the program, while only 11 percent of individuals in Utah are enrolled, and fewer than 15 percent of individuals in North Dakota, Wyoming, New Hampshire, South Dakota, and Kansas are enrolled in the program (Rudowitz et al. 2024). Importantly, in recent years Medicaid growth has been high in traditionally red congressional districts, with particularly high growth in rural, poor, and white congressional Republican districts, making the politics of cutting this program much more complicated than they have been in the past (Geruso et al. 2025).

Another final way to consider beneficiaries is to examine where Medicaid spending ultimately ends up—that is, at medical providers. The burden of serving Medicaid patients is not evenly spread across providers and therefore neither is the program's

impact. In particular, hospitals often find themselves treating a disproportionate number of Medicaid patients. This disproportion arises partly because hospitals are required to treat patients entering through the emergency room and thus often become the provider of last resort when access is limited. Research has shown that when the share of uninsured residents increases in a market, so does uncompensated care at local hospitals. Hospitals are unable to recoup these funds from other sources and instead suffer economic losses. It is for this reason that the ACA Medicaid expansions had some benefits for hospital finances (Dranove et al. 2016). It is also likely for this reason that hospitals are such strong supporters of Medicaid and the ACA. It is unclear whether the emergency room is the most appropriate site of care for these patients and/or whether earlier access to care could reduce the severity of their medical conditions.

2.2 Financing

Financing for the traditional Medicaid population has remained largely consistent over time. Despite the creation of a ceiling and a floor, the same general FMAP rules laid out at the start of the program remain in operation today.

The biggest changes to the FMAP system have occurred for each of the various expansion populations. For example, the CHIP program expanding Medicaid coverage to children with modestly higher incomes included an "enhanced" FMAP to encourage states to cover more children. These FMAPs have a floor at 65 percent (i.e., the federal government pays 65 percent of Medicaid costs) instead of the standard 50 percent floor, and they go up as high as 85 percent depending on a state's income.

The FMAP was further expanded for the ACA Medicaid expansion—which is almost entirely paid for with federal dollars. This high match rate turned out to be critical when the Supreme Court made the ACA Medicaid expansion optional instead of mandatory, as many, if not most, states likely would not have opted to expand Medicaid with typical FMAP rates. Indeed, recent proposals to cut Medicaid spending by lowering the ACA expansion FMAP from 90 percent down to the standard rates have been met with outcry from many groups concerned that states would react to this shift by dropping the expansion population altogether (Williams et al. 2025). Some states even have specifically built in automatic exits from the expansion if FMAPs decrease.

Beyond modifications to the FMAP system, states have also been able to boost federal matching funds via other methods discussed above. Through a combination of various provider-tax systems, states have increased the share of the program paid for with federal dollars. In 2024, the CBO estimated that the elimination of Medicaid provider taxes would save the federal government over $600 billion over ten years

(CBO 2024), implying that states bring in substantial federal dollars via these schemes. In some states, matching payments from provider taxes amount to over one-third of total Medicaid program finances (Sanger-Katz and Kliff 2025). States also use other loopholes, such as transfer payments from publicly owned nursing homes and hospitals, to achieve similar flows of federal matching payments.

All these changes combine to make actual effective FMAPs somewhat higher than the intended matching payments, though comprehensive estimates of the actual difference between intended FMAP and actual FMAP are hard to come by, but we do know the overall state-versus-federal split, with the federal government paying around 69 percent of the total Medicaid bill in 2023 (Burns et al. 2025). Ultimately, however, the simple fact is that today the federal government subsidizes state Medicaid spending on the margin at a much higher rate than it originally did at the beginning of the program or likely than is intended under current regulations. However, that spending also represents real payments to providers that would need to be accounted for if these systems were limited.

2.3 Scope of coverage and provider payment rates

As in the beginning of the program, federal rules still generally require states to cover most medical services, with limited flexibility allowed for excluding services from coverage. Eligibility rules have also become more standardized and determined at the federal level. As a result, states are left with limited means to control Medicaid spending, other than by paying very low rates to providers. Low rates keep spending down both in that providers are paid less for the same services and due to upward-sloping supply curves, as few providers are willing to accept the low rates and so less care is available to Medicaid enrollees in the first place.

The Kaiser Family Foundation estimates that on average, across the country, Medicaid pays rates equal to about 72 percent of Medicare rates (KFF n.d.a.). Rates tend to be higher for obstetric care and lower for primary care. They also vary significantly across states, with rates near or above Medicare rates in some states (South Carolina, North Dakota, Nebraska, Alaska, Montana, Delaware) and with rates below 60 percent of Medicare in other states (Illinois, Florida, New Hampshire, New York, New Jersey, Rhode Island). As in the past, provider payment rates don't closely track politics, with some blue states having some of the lowest rates. Historically, this outcome had reflected blue states prioritizing generous eligibility rules over payment rates, but as eligibility has become more standardized nationwide, rates have not meaningfully converged.

These generally low rates have led to a situation where Medicaid patients have a much harder time finding a doctor than other patients do. Data from 2017

show that while around 96 percent and 88 percent of physicians were accepting new commercial and Medicare patients, respectively, only around 74 percent of physicians were accepting new Medicaid patients (MACPAC 2021). "Secret shopper" studies put Medicaid acceptance even lower, around 60 percent, relative to 86 percent for private insurance (Polsky et al. 2015). Even after getting an appointment and arriving at the office, Medicaid patients wait longer to be seen (Oostrom et al. 2017). Overall Medicaid acceptance rates varied substantially across specialties, with high acceptance rates among pediatricians, surgeons, and OB/GYNs and particularly low acceptance rates among dermatologists and psychiatrists. Acceptance rates also varied significantly across states, with rates as low as 42 percent of providers in New Jersey and 55 percent in Florida—and rates essentially at parity with commercial acceptance rates in North Dakota and Minnesota (Hest 2022).

Solid evidence suggests a causal link between low provider-payment rates and low Medicaid acceptance rates. A natural experiment where Medicaid rates increased temporarily nationwide resulted in an increase in physicians willing to see Medicaid patients (Alexander and Schnell 2024; Polsky et al. 2015). These results suggest that setting Medicaid payment rates close to commercial rates would "reduce more than half of disparities in access among adults and would eliminate such disparities among children" (Alexander and Schnell 2024). Similar evidence shows that Medicaid payment rates also matter for access to care for those dually enrolled in Medicaid and Medicare (Cabral et al. 2025).

Beyond payment rates, state Medicaid programs also often make it fairly difficult for providers to *actually get paid*. Data suggests that fee-for-service (FFS) Medicaid is the biggest denier of bills from providers, with a "denial rate 17.8 percentage points higher than fee-for-service Medicare" (Gottlieb et al. 2018). Medicaid managed care is the second-most likely to deny, denying just under 10 percent of bills and challenging around 13 percent. Both FFS and managed-care Medicaid also have much longer times to payment, making working with Medicaid a much bigger hassle for providers than working with Medicare or commercial insurers. Solid evidence suggests a causal relationship between these hassles and physicians' willingness to accept Medicaid patients (Dunn et al. 2024).

For drugs, states are also still required to cover most drugs if they want to participate in the federal rebate program and receive the "best price" for their drugs. In recent years, states have started to experiment with formularies that restrict use of some drugs via prior authorization rules, but outright exclusion is generally not allowed. States still use quantity limits on drugs, though those have become less prevalent over time.

2.4 Effects of Medicaid on beneficiaries

Given its relatively stingy nature, many have questioned whether Medicaid actually benefits enrollees. These questions are also driven by evidence that the uninsured actually pay only very little of their medical bills. Evidence indicates that out-of-pocket costs for an uninsured individual actually appear quite similar to out-of-pocket costs for an individual on a high-deductible plan, with the uninsured only really ending up on the hook for a relatively small portion of their total healthcare bills: Out-of-pocket payments for uninsured individuals with charges higher than $50,000 rarely surpass $10,000 (Mahoney 2015). Recent evidence from a large randomized trial has also shown that paying off an individual's medical debt has only limited impacts on those individuals across a wide variety of outcomes, suggesting that the consequences for not paying medical bills are quite limited and raising questions about the value of insurance to beneficiaries (Kluender et al. 2025)

This ambiguity regarding the benefits of Medicaid for beneficiaries has led to a large academic literature estimating the effects of Medicaid coverage on beneficiaries, including a large-scale randomized trial, the "Oregon Health Insurance Experiment" (Finkelstein et al. 2012). This literature generally focuses on expansion populations rather than on the initial categorically eligible groups. Overall, the results indicate that Medicaid clearly provides real benefits to these enrollees—albeit with mixed evidence across studies on the exact nature of the benefits.

First, there is solid quasi-experimental evidence that Medicaid coverage is beneficial for children. Kids who were eligible for Medicaid for more years due to a policy change were less likely to have hospitalizations and ED visits during adulthood and also saw a decline in disease-related mortality later in life (Wherry et al. 2018; Wherry and Meyer 2016). Medicaid coverage during childhood has also been shown to lead to higher incomes later in life, thereby generating enough additional tax revenue to offset 58 cents of each dollar spent on childhood Medicaid coverage (Brown et al. 2020).

Second, solid evidence indicates that expansions to cover pregnant women and infants also achieved important improvements in outcomes. Quasi-experimental studies show that Medicaid coverage of pregnant women decreases infant mortality and leads to fewer low-birth-weight births (Currie and Gruber 1996). Research also indicates that coverage of pregnant women leads the children of those women to have lower rates of chronic conditions and fewer hospitalizations as adults, with some evidence also indicating higher high school graduation rates for these children (Miller and Wherry 2019).

Finally, more recent work has focused on effects for ACA expansion populations, primarily low-income adults. This is the population studied by the Oregon Health

Insurance Experiment. This experiment leveraged the fact that, prior to the ACA, the state of Oregon had additional funds to expand eligibility but insufficient funds to provide coverage to all who desired it. The state thus decided to allocate coverage via a randomized lottery among those who applied, generating the opportunity to estimate the effects of Medicaid coverage using the gold-standard method of a randomized trial, typically reserved for testing the effects of new pharmaceuticals. The state-by-state roll-out of the expansion has also led to a significant body of quasi-experimental work focusing on this population. The Oregon experiment showed clear increases in healthcare utilization and clear improvements in financial health and self-reported physical and mental health (Finkelstein et al. 2012). The Oregon experiment also investigated biomarkers of health but did not find statistically significant improvements, at least partially due to relatively small sample sizes. Quasi-experimental work has also shown clear health benefits for enrollees, including reductions in mortality (Sommers et al. 2012; Wyse and Meyer 2025; Miller et al. 2021). This work has also validated the Oregon results on improved financial and self-reported health (Hu et al. 2018). Overall, this body of work has put to rest the idea that Medicaid does not improve the lives of beneficiaries, both in terms of their health and also in terms of broader well-being.

Despite the clear benefits for enrollees, evidence also indicates that a substantial share of the benefit of Medicaid coverage does not accrue to the enrollees themselves but instead accrues to healthcare providers. This finding should not be surprising given the evidence that the uninsured actually pay very little of their medical bills. Indeed, the Oregon study showed that, setting health benefits aside, for every $1 of Medicaid spending, beneficiaries only get between 20 and 40 cents in welfare benefit (Finkelstein et al. 2019). Healthcare providers, on the other hand, receive around 60 cents of benefit for every $1 of Medicaid spending. Quasi-experimental work backs this finding up, showing that in the absence of Medicaid, hospitals act as "insurers of last resort" absorbing a piece of the cost of uncompensated care (Garthwaite et al. 2018). The "incidence" of Medicaid is thus roughly evenly split between beneficiaries and providers, with each receiving substantial benefits from expansion of the program. Ultimately, these results indicate that Medicaid is a major transfer to providers, and the success of the efficiency of the program depends at least partially on how those transfers are used.

2.5 Most-common Medicaid reform proposals

Medicaid reform is in constant discussion among policymakers and politicians, and it played a major role in the recent budget bill passed by the House and Senate and recently signed into law by President Trump. While a variety of specific proposals have been put forth over the years, they broadly fall into three economic buckets.

First, there are reforms that modify the current FMAP rates to decrease the share of federal spending. Second, there are reforms that impose various administrative burdens and work requirements on beneficiaries in an attempt to (1) better target Medicaid enrollment to particularly needy groups and encourage labor force participation and (2) potentially use administrative hassles to decrease enrollment and thus costs. Third, there are reforms that essentially abandon the existing FMAP system altogether and replace it with either caps on total federal dollars going to states or pre-specified block grants and broader state-policy flexibility.

Beginning with the first bucket, the most commonly discussed FMAP reform is a reduction of the ACA expansion rate from 90 percent. This higher FMAP obviously makes expansion more attractive to states, but it also imposes high costs on the federal government. Beyond increasing enrollment, the higher FMAP provides states with an incentive to increase per-enrollee spending because of the higher marginal subsidy. Indeed, evidence suggests that the higher-expansion FMAP led to a higher level of per-enrollee spending (Bundorf and Kessler 2022).

Proposed reforms have ranged from modest decreases in the expansion FMAP (i.e., moving from 90 percent to 80 percent) to equalizing the expansion FMAP to the standard FMAP. There are also some revenue-neutral discussions of equalizing the FMAP to a single rate across all expansion groups—which would have disparate impacts across states based on the distribution of enrollees across expansion populations. These FMAP reductions could have substantial impacts on Medicaid coverage, as a number of states opted for expansion primarily because of the higher matching rate and thus may no longer find these policies optimal and/or feasible. As a testament to this point, some states even included automatic exit clauses that are triggered if the FMAP is lowered below the 90 percent level. Thus, this type of reform would likely reduce overall Medicaid spending substantially, but entirely via decreased eligibility and enrollment. Even without exiting entirely, states may be forced to make changes to eligibility generosity as they lack the revenue to replace the decreased federal funds.

A more subtle reform to the FMAP system involves restrictions on the types of "fiscal shenanigans" states engage in to exploit the federal matching payments. As discussed above, these "shenanigans" include provider (and managed-care plan) taxes, transfer payments with public providers, and more. All these schemes act to increase the effective federal match rate. Though such schemes are not intended by the FMAP system, almost all states engage in them, and many states are highly reliant on the revenues that they generate for funding their Medicaid programs (Sanger-Katz and Kliff 2025).

For many years, reforms restricting these types of schemes have been proposed. The CBO frequently scores these proposals, finding that eliminating them could save at least $600 billion over ten years (CBO 2024). Given many states' (including red states) reliance on these schemes, reform has been politically difficult, though the recent budget bill does impose some modest restrictions on these schemes. Note that while these schemes increase effective matching rates above the intended matching formulas, they bring real federal dollars to state Medicaid programs—dollars that, if lost, would either have to be replaced with additional state revenue or that would result in cuts to Medicaid benefits in one form or another. The latter is more likely than the former in most cases, (as we discussed earlier) Medicaid already eats up a substantial portion of state budgets, and there is limited room or appetite for additional Medicaid spending at the state level.

The second bucket of reforms involves administrative burdens and work requirements. While work requirements are framed as promoting work and ensuring program integrity, evidence suggests that they have little impact on labor supply but do significantly reduce enrollment, largely by creating administrative burdens that cause even eligible individuals to lose coverage (Sommers et al. 2019; Gray et al. 2023; CBO 2023). Similarly, more-frequent eligibility redeterminations may screen out currently ineligible individuals, but they also screen out those who are eligible but neglect to go through the redetermination process due to competing demands for attention, the complexities of the process, or simply forgetting. Importantly, these reforms achieve cost savings almost entirely by reducing the number of people covered, rather than by making the program more efficient or improving access for those who remain. They are policies of rationing, not structural improvement. They can result in a less-expensive Medicaid program that is better-targeted to the neediest individuals (though these burdens can easily screen out needy individuals as well [Finkelstein and Notowidigdo 2019])—but at the cost of increasing the number of Americans who are uninsured.

The last bucket of reforms involves an end, or major modification, to the very existence of the FMAP system. For many years, Republicans have proposed shifting Medicaid financing to a "block grant" model where states receive a fixed amount of money every year to finance their Medicaid programs. While in the past, proposals did not scale block grants with enrollment, most proposals today involve per-enrollee payments. This new model would mark an end to the existing program structure where the federal government subsidizes state Medicaid spending on the margin. Instead, states would be responsible for all spending above the block grant. The motivation for this type of proposal is to encourage states to make their programs efficient, end "waste, fraud, and abuse," and put an end to all types of "fiscal shenanigans" that exploit the FMAP system to bring in more federal dollars.

The major difficulty with this type of proposal is determining a formula for a state's block grant. Obviously, states are very different, and the cost of providing care to a Medicaid enrollee in New York City is very different from the cost of providing care to a Medicaid enrollee in rural Alaska. Many proposals set block grants based on current spending, but that type of system tends to favor blue states that spend more on their programs and disfavor red states with more stingy programs, making the politics of these types of proposals difficult. In contrast, a proposal that is more uniform across states might appear more politically fair but could ignore important differences in the costs of local healthcare markets.

Beyond politics, a major concern with this type of system is that states face pressure to keep taxes low and safety net programs stingy in order to attract higher-income residents and businesses. This pressure can lead to a "race to the bottom" in safety net coverage and Medicaid program generosity. Some subsidy on the margin can limit this race to the bottom and achieve a reasonably generous safety net while still maintaining an incentive for states to restrain program costs. In fact, as discussed above, this trade-off was a primary motivation for the existing structure of the program.

Partially because of these issues, the most commonly discussed reforms in this area are more often described as "per-capita spending caps." These reforms generally consist of normal FMAP federal matching payments up to a cap, where the cap is set based on past spending plus medical inflation or medical inflation minus some fixed amount. The idea behind these caps is to still use the matching system but to end the unlimited nature of the match and put some constraint on future state spending. This type of cap would likely decrease "fiscal shenanigans" substantially, as states would only be reimbursed for these schemes up to a point. It would also encourage states to identify efficiencies. But it could also lead states to limit valuable services via prescription drug caps, lower provider payment rates, and the dropping of optional benefits like dental coverage. Lawmakers discussed including these types of per-capita caps in the recent budget bill, but the final bill did not include them.

Importantly, unlike the other buckets of reforms, this bucket does not focus on cost savings from reduced enrollment. It instead shifts state incentives and the financing model. For this reason, in most cases, we might expect this type of reform to maintain enrollment levels but make Medicaid a less generous program. In the next section, we discuss a broader reform that would attempt to do something similar, though via different methods.

3. A roadmap for discussing broader Medicaid reforms: An abundance agenda for Medicaid

To date, debates about Medicaid reforms have primarily focused on changes to generosity that keep the existing program structure intact. However, as discussed above, this structure was originally developed for a program with a far smaller scale and breadth. At that scale, the safety net had less impact on providers, many of which were willing to treat the relatively small number of patients per provider for little return as a form of a contribution to the general public good (either because of implicit tax-status obligations or provider altruism). For this reason, it seemed optimal to primarily finance the provision of care and leverage the existing supply infrastructure.

It is perhaps not surprising that the program was structured in this manner. After all, this made it similar to nearly all other forms of social insurance (including the simultaneously created Medicare program) that have little reason to contend with the supply side of services. Consider programs such as unemployment insurance, SNAP (i.e., food stamps), or WIC (women, infants, and children). In these programs, debates about optimal policy are similar to today's Medicaid conversation—that is, they largely revolve around the generosity of benefits and perhaps the scope of beneficiary freedom (i.e., which products can be bought in food security programs). However, little thought is given to directly influencing the existence or structure of the market for goods and services.

As described above, Medicaid now covers one in four Americans, meaning it no longer accounts for only a trivial share of providers' business. It is thus now very different from safety net programs like SNAP and WIC, where beneficiaries of those programs make up a very small share of grocery store customers. In addition, in these other in-kind social-insurance programs, providers are compensated at market rates, whereas Medicaid pays rates well below the commercial level. As Medicaid grows as a fraction of the market, its focus on paying very little for care on the margin has greater implications for the strategy of providers. Many find that they now must either limit exposure to Medicaid or change their fixed-cost investments—which can have negative impact on commercially insured patients. This financial precarity of providers that opt to treat Medicaid patients suggests that a new focus of Medicaid policymakers on the supply side could help improve the program for beneficiaries. Many have begun to push for a shift of focus of health policy, energy policy, and housing policy more generally from subsidizing demand to fostering an abundance of supply (Mansell 2024; Klein and Thompson 2025). We argue that a specific shift in focus for Medicaid policy is also needed.

3.1 An analogy to housing policy

Despite its clear differences from other social-insurance programs, some other safety net programs, housing programs in particular, may provide some insight into how a more supply-focused Medicaid might be optimally designed—at the very least as a thought exercise. In particular, these programs may be further along in the evolution of government policy that more explicitly considers the impact of program design on the supply side, even though they face more-extreme funding constraints than healthcare programs like Medicaid do.

Reforms in housing policy provide a useful, if imperfect, analogy for how to think about reforming Medicaid. Like Medicaid, federal housing assistance has traditionally focused on subsidizing demand, primarily through rental vouchers that function much like an insurance card. However, policymakers learned that subsidizing demand was insufficient to create an adequate supply of affordable units, as landlords often had little financial incentive to serve voucher holders. In response, policy evolved to more directly subsidize the supply of affordable housing through tools like project-based rental assistance (PBRA) and the Low-Income Housing Tax Credit (LIHTC), which provide direct support to developers who, in exchange, restrict their properties to low-income households (though much more support appears to be needed to solve current housing problems). While such a policy explicitly fosters a two-tiered system of housing quality that some may find objectionable, it confronts the reality that the alternative for many voucher holders is not higher-quality housing but no housing at all. This state of affairs mirrors the situation in healthcare, where an implicitly two-tiered system already exists; many Medicaid beneficiaries have coverage on paper but struggle to find providers willing to see them. Therefore, a reform that explicitly supports the supply of a dedicated tier of Medicaid providers—even if it differs from the commercial tier—may be superior to the current system, as it would ensure abundant access to adequate care rather than rationed access to none. In the same way that the return of boarding houses could improve the lives of many on the margin of homelessness (Yglesias 2021), a new (or expanded) tier of very basic healthcare services and providers could improve the lives of Medicaid beneficiaries who currently have difficulty accessing any healthcare at all.

The fundamental economics of any safety-net business, whether housing or healthcare, are the same: They are low-margin enterprises that, to be cost-efficient for government budgets, must provide a product at a different quality standard than the private market. To encourage an abundant supply of these services, policy must do two things: guarantee a high volume of customers so providers can be profitable

at scale, and subsidize the high fixed costs required to build capacity. Healthcare is no different. It is a rivalrous good with clear quality variation across providers (Doyle et al. 2015; Garthwaite et al. 2022; Cooper et al. 2022). Yet applying these economic principles is complicated by a unique feature of medical care: It is difficult for a single facility to offer different tiers of service, as physicians generally treat all patients who walk through their door with the same standard of care.

This inability to screen on quality within a facility creates an untenable dilemma for providers now that Medicaid covers a quarter of the population. Providers who treat both commercial and Medicaid patients cannot set a single quality-and-cost structure that is simultaneously attractive to high-paying commercial customers and financially viable for their large number of low-paying Medicaid patients. The result is predictable: Providers opt out of Medicaid or severely limit access, creating the current crisis. Even for providers who do specialize in Medicaid, the low reimbursement rates are often insufficient to cover the high fixed costs of healthcare infrastructure. Existing fixed-cost subsidies like DSH payments are opaque, poorly targeted, and do little to support the development of crucial non-hospital services (Dranove et al. 2016). A successful reform agenda must therefore move beyond subsidizing demand and directly confront these supply-side realities by creating a system where an abundant number of providers can operate sustainably.

3.2 Embracing the existing two-tiered healthcare system

A meaningful reform of Medicaid must begin from a new premise: The goal is to provide abundant, cost-efficient access to basic healthcare, not to prop up an existing system that fails to deliver. The current program is defined by a stark economic tension—it promises access to the mainstream medical system while only providing the funding that can support a two-tiered one. This contradiction was manageable when Medicaid was a small program, but now that it covers a quarter of Americans, there is potential for an access crisis. Policymakers must therefore confront a fundamental choice: Continue to chase the mirage of equal access, or build a system that delivers abundant care to *all* Medicaid beneficiaries within its budget.

"An honest assessment reveals that an implicit—and dysfunctional—two-tiered system is already the reality."

We argue for the latter. An honest assessment reveals that an implicit—and dysfunctional—two-tiered system is already the reality. The promise of equal access is belied by the fact that a small fraction of physicians provide the vast majority of care for Medicaid patients; for example, just 25 percent of primary-care physicians and

psychiatrists handle 80 percent of Medicaid claims (Ludimorsky et al. 2022). For many beneficiaries, the alternative to this concentrated, lower-cost tier is not care from a top-tier hospital or a highly demanded primary-care physician but no care at all. Our core proposal is to explicitly "own" this two-tiered structure. This approach means shifting Medicaid's focus from subsidizing demand for a system that won't serve its patients to directly stimulating the supply of a dedicated tier of lower-cost providers that will. The goal is to create an abundance of basic care by lowering costs and improving the business model for providers who commit to the Medicaid population, a strategy that prioritizes real access over rhetorical equity.

3.3 Targeted relaxation of quality regulations and regulatory burdens for the Medicaid tier

Our proposal is to lower the cost of providing basic care by strategically relaxing regulations on the most expensive input: clinical labor. Regulators face a fundamental trade-off: A single, high quality-floor for all providers can be so expensive to meet that it pushes low-income consumers out of the market entirely, leaving them with no care at all. For Medicaid, this trade-off means that the effect of quality regulation is a shift from lower-cost basic care to no care, not from basic care to high-quality specialized care. We propose creating a specific, less burdensome regulatory environment for providers who commit to the Medicaid tier, allowing them to build sustainable, lower-cost business models. This approach has two core, interconnected components: (1) expanding the clinical workforce of Medicaid providers, and (2) augmentation of this expanded workforce with artificial intelligence (AI).

Expanding the clinical workforce of Medicaid providers: First, providers who commit to this Medicaid tier should be given relief from many healthcare regulations and ex-ante relief from a variety of forms of litigation. A variety of licensing requirements and scope-of-practice laws make it difficult to expand the supply of low-cost medical care. Further, health insurers, public and private, are often sued when they try to implement cost-cutting reforms. Obviously, providers and insurers should still be accountable for gross negligence and other forms of obvious medical malpractice, but healthcare litigation also often holds providers and insurers responsible for not providing or covering expensive services whose value is quite low relative to the cost. Such care often does not fit the socially held belief in access to basic healthcare for all. Indeed, it is this type of litigation that has at least partially led to the very wide scope of coverage required by the Medicaid program today. Medicaid providers should be relieved from the risk of this type of litigation, with cost being a valid legal reason for not providing certain services (at least up to some limit).

We argue that *all* healthcare quality regulations should be examined for this type of "tiering," but here we point to two areas that might be particularly fruitful in the short run:

1. Policies related to the supply of international medical-school graduates (IMGs)
2. Scope of practice laws for mid-level providers

Consider first the question of IMGs. A number of regulatory hurdles make it difficult for these highly trained individuals to practice in the US. Two important features are residency requirements and visa restrictions. Both of these features could be modified—and have historically been loosened for doctors who deal with underserved areas. For example, the "Conrad 30" waiver program allows visa holders who otherwise would be required to return home for a period of two years to work instead in underserved markets in the US for a period of time. Such programs could be expanded to include waivers of residency requirements entirely for sufficiently trained international medical graduates willing to work at particular facilities serving Medicaid patients. An expanded tranche of visas could also be offered with the condition that these providers *only* treat Medicaid patients or work at facilities that treat a high percentage of Medicaid patients and the requirement that they must treat a certain number of patients for a certain number of years to maintain residency. Evidence suggests that even modest financial incentives can induce domestically trained physicians to practice in areas that they otherwise wouldn't choose to practice in, so it seems likely that these types of programs could be effective at boosting supply for Medicaid patients (Davis et al. 2023).

The second set of highly trained providers are often described as "mid-level providers" or "advanced-practice clinicians." While these individuals do not receive the exact same level of education or training as physicians, they do have advanced degrees and meaningful amounts of clinical training. However, the ability of these individuals to provide healthcare is governed by "scope-of-practice" laws that dictate how much autonomy these providers enjoy. Our proposal is to relax these laws when these providers are treating Medicaid patients or working in facilities that treat high percentages of Medicaid enrollees. This type of targeted increase in flexibility and freedom could even have the impact of increasing the attractiveness of these types of credentials and positions. Importantly, there are many fewer constraints on the expansion of training programs for these types of providers, meaning that it is possible that an increase in demand for these types of providers and an increase in the freedom and attractiveness of these types of jobs could actually be met with an increase in supply, something that is not as feasible for an increase in demand for MDs.

While there is meaningful ongoing debate about the clinical-care quality offered by mid-level providers, a number of high-quality studies show that granting more autonomy to these providers increases access to care without overall negative health impacts. For example, McMichael (2023) finds that great autonomy for NPs and PA reduced mortality. This reduction was particularly pronounced in rural areas where supply could be especially constrained (McMichael 2023). Alexander and Schnell (2019) find that greater prescribing authority for mid-level providers increases population-wide mental health. Even setting this evidence aside, again it is important to note that for the Medicaid population the correct comparison may not be to fully-fledged physicians but instead to no care at all.

Augmenting the expanded workforce with AI: To address concerns about quality variations from an expanded workforce of International Medical Graduates (IMGs) and mid-level providers, our proposal pairs the expanded use of these clinicians with the broad adoption of artificial intelligence. While the commercial market has been slow to implement AI tools due to litigation fears and patient reluctance, the Medicaid tier provides a unique and valuable opportunity for innovation. For a beneficiary whose alternative is no access to care, the use of a new, well-designed technology is a clear improvement. Loosening regulations to allow for AI-augmented care in healthcare safety-net facilities creates a safe harbor to experiment and learn, which is crucial given that some evidence suggesting that AI alone can outperform the combination of AI and human judgment in certain tasks (Agarwal et al. 2023). With a good enough AI-enabled system, one might even imagine other large groups of providers, like social workers, EMTs (where training can take just weeks or months), or even a brand-new class of low-cost AI-augmented providers, being able to step in and provide basic healthcare diagnostic services.

This synergy—a larger, lower-cost workforce amplified by technology—is the key to creating an abundant supply of high-quality basic care. The vision is a functional two-tiered system where the Medicaid tier is characterized by broad access to IMGs and mid-level providers who are augmented by AI tools. These tools, trained on the actions of elite physicians in the commercial market, would create a virtuous cycle, allowing the expertise of top specialists to be scaled efficiently across the entire system. This approach allows all clinicians to practice at the top of their license and enables new, more efficient business models to emerge. Ultimately, it creates a true "abundance agenda" for the healthcare safety net, shifting the focus from rationing high-cost care to delivering accessible, high-quality basic services to all who need them.

3.4 Which facilities can gain access to these new safety-net policies?

A question remains as to which providers and facilities would be subject to the less stringent set of regulations. As discussed above with the analogy to housing, the types of reforms we propose are most likely to benefit Medicaid patients if they are restricted to providers who treat Medicaid patients, and if benefits are not allowed to "spill over" to non-Medicaid patients. Such spillovers could lead higher-income patients with weak preferences for quality to also desire to use this low-quality but easy-access tier of providers, potentially crowding out Medicaid patients and shifting the incidence of supply-side subsidies away from the intended low-income patients and toward less-needy, higher-income groups who are capable of covering these costs on their own. One option would be to say that these regulatory relaxations apply only when treating Medicaid patients. However, the relaxations are generally provider-focused, and it is difficult for a single provider to treat different patients differently. This point will not be a problem if the healthcare system rapidly becomes a truly two-tiered system where providers either treat only Medicaid patients or only non-Medicaid patients. But such a complete tiering seems unlikely, at least in the short term, implying that some other provider-level rule must determine eligibility for regulatory relaxations, one that recognizes that providers treat both Medicaid and non-Medicaid patients.

Here, we suggest that geography plays a major role. When it comes to healthcare utilization, physical location is a driving factor, if not the decisive factor, in determining the selection of medical providers. As such, travel distances for healthcare are relatively short—with a median for hospital care of only six miles (Weiss et al. 2021).

Much as in the old saying about politics, all healthcare is local. The micro-geography of healthcare matters immensely for access and availability. As a result, the economics of a provider's local area can dictate their strategy. It is perhaps not surprising that given existing reimbursement policies, markets dominated by patients who are on Medicaid and uninsured require specific strategies to be able to succeed financially. This state of affairs would suggest that a starting place for discussion is the creation of a set of place-based policies and supply-side subsidies that facilitate the construction of new facilities. Creating such policies would involve targeting relatively small geographic areas that either (a) are underserved or (b) have a large proportion of patients eligible for Medicaid.

One could imagine that a place-based relaxation of the regulations discussed above could cause the construction (or conversion) of a set of safety-net facilities in underserved areas. Such facilities would be allowed more flexibility in staffing and scope of practice regulations, thereby enabling a basic set of services to be provided in a cost-efficient manner.

3.5 *Revenue-based policies*

Regulatory relief alone is likely not enough; to foster an abundant supply of providers for the Medicaid tier, policy must also reform how they are paid. The current fee-for-service model is insufficient to cover the high fixed costs—for facilities, technology, and staff—required to enter the market. Therefore, we propose that providers who commit to the Medicaid tier gain access to new revenue opportunities that directly subsidize these fixed costs. Such opportunities could include state or national investments in AI tools that are then provided to all Medicaid-tier clinicians, or direct grants to support the construction and operational costs of new facilities. Such subsidies would ensure that providers who make the strategic decision to serve the Medicaid population can operate sustainably, earning profits through high volume rather than high per-service margins.

However, simply subsidizing the fixed costs of a new, lower-cost tier of providers is not sufficient to guarantee their success. A market failure arises from the demand side: If Medicaid beneficiaries, whose care is fully subsidized, are free to choose any provider, they have little incentive to select the most cost-efficient option. Some may instead seek care from higher-cost, higher-quality providers, leaving the new Medicaid-tier facilities without the patient volume necessary to achieve economies of scale and remain financially viable. Because taxpayer dollars are financing this system, the government has a clear role and a strong incentive to intervene. It must actively manage the market it is creating to ensure that the cost-effective providers it fosters can succeed.

This government intervention should focus on ensuring patient volume for the designated Medicaid tier. A direct approach, common in the national health systems of other developed countries, is for the government to actively steer patients. It can do so by creating restrictive networks for certain services or by implementing higher cost-sharing for patients who choose to receive basic care outside the designated Medicaid tier. This approach guarantees a stable customer base for Medicaid-tier providers, making their business model viable and ensuring that public funds are spent efficiently.

Evidence from FQHCs demonstrates the promise of this supply-focused funding model. Studies show that when FQHCs receive direct grant funding—a form of fixed-cost subsidy—they increase primary-care access for low-income patients and reduce inefficient, non-emergent use of the emergency department (Lo Sasso and Byck 2010; Myong et al. 2020). Importantly, these lump-sum payments also give facilities the flexibility to offer services that are not traditionally reimbursed but are often crucial for the Medicaid population, such as behavioral-health and social-work support. This evidence proves that moving beyond a simple fee-for-service system and directly funding supply can lead to more efficient, effective, and holistic care.

3.6 How could these policies be financed?

This supply-focused reform does not necessarily require new spending. Instead, it can be financed by repurposing funds from the two largest existing—and deeply inefficient—supply-side subsidy programs: direct provider payments like the Disproportionate Share Hospital (DSH) program, and the indirect subsidies provided by the 340B Drug Pricing Program. Both programs channel billions of dollars to providers but do so in opaque and poorly targeted ways. Reforming and redirecting these funds can provide the capital needed to build a new, abundant supply of care for the Medicaid tier.

First, consider DSH and other state-directed payments. These programs already function as fixed-cost subsidies, intended to compensate providers for the high cost of uncompensated and Medicaid care. However, they are notoriously opaque, are subject to fiscal gamesmanship by states, and do little to encourage the development of new, efficient models of care, particularly outside the hospital setting. These billions in existing payments should be repurposed into transparent, targeted grants to subsidize the actual fixed costs of building the Medicaid tier, such as facility construction, rent, and the adoption of new AI technologies.

The second, larger source of funds is the 340B program. While not a direct government outlay, 340B functions as a massive indirect subsidy, funded by what is effectively a tax on pharmaceutical manufacturers passed on to commercially insured patients. The program allows eligible hospitals and clinics to purchase drugs at exceptionally low prices and generate large margins by selling them to commercially insured patients. Originally intended to help a small number of safety-net facilities, the program has exploded in size, yet there is little evidence that these windfalls are used to expand care for the poor; indeed, newer participants provide even less charity care than the original ones (Nikpay et al. 2020; AIR 340B 2023).

Given its scale and inefficiencies, the 340B program is ripe for reform. Instead of simply generating untargeted profits for hospitals, access to 340B discounts could be explicitly tied to a provider's commitment to the healthcare safety net. For example, the size of a hospital's 340B discount could be directly proportional to the share of its patients covered by Medicaid. This approach would transform the program from an opaque cross-subsidy into a powerful and direct financial incentive for providers to build and expand capacity for the Medicaid tier, effectively using a market-based mechanism to solve the supply crisis.

Conclusion

Medicaid is, by many measures, a remarkable policy success. It has grown from a niche program into one of the largest public health insurers in the world, providing essential coverage that improves the health and financial well-being of nearly a quarter of all Americans. Medicaid does amazing things for beneficiaries, improving health, finances, and well-being. It has proven itself a good investment when given to children. Increasing numbers of Americans depend on it and approve of its expansion.

Yet this success is shadowed by a fundamental design flaw. The program's core tension—promising access to mainstream care while paying rates too low for most mainstream providers to accept—has created a crisis of access. For millions of beneficiaries, Medicaid is an insurance card that provides comprehensive coverage for care they cannot find.

With its dramatic growth in size and scope, Medicaid requires a re-evaluation of its core design. We argue that reform efforts should shift from the traditional focus on eligibility and financing to the more fundamental challenge of supply. This paper proposes an "abundance agenda" for the healthcare safety net. We explicitly recognize that an implicit two-tiered system already exists, and we argue for making that system functional. By relaxing specific regulations and leveraging technology, we can foster a dedicated tier of providers who can operate sustainably at Medicaid's price point. The goal is to transform the program's promise from rationed access to high-quality care into abundant access to basic care, ensuring that the program's resources deliver the greatest possible value to the people it is meant to serve.

References

ACU and Capital Link. 2018. *Identifying Workforce and Financial Characteristics of High-Performing Health Centers.* Association of Clinicians for the Underserved and Capital Link. Identifying_Workforce_and_Financial_Characteristics_at_High_Performing_Health_Cente.pdf.

Agafiev Macambira, Danil, Michael Geruso, Anthony Lollo, Chima D. Ndumele, and Jacob Wallace. 2022. "The Private Provision of Public Services: Evidence from Random Assignment in Medicaid." Working paper no. 30390. National Bureau of Economic Research, August; revised January 2025. https://doi.org/10.3386/w30390.

Agarwal, Nikhil, Alex Moehring, Pranav Rajpurkar, and Tobias Salz. 2023. "Combining Human Expertise with Artificial Intelligence: Experimental Evidence from Radiology." Working paper no. 31422. National Bureau of Economic Research, July; revised March 2024. https://doi.org/10.3386/w31422.

AIR 340B. 2023. *Charity Care at 340B Hospitals Is on a Downward Trend.* Alliance for Integrity and Reform, October. 2023-Charity-Care-Report-Final-1.pdf.

Alexander, Diane, and Molly Schnell. 2019. "Just What the Nurse Practitioner Ordered: Independent Prescriptive Authority and Population Mental Health." *Journal of Health Economics* 66: 145–62.

Alexander, Diane, and Molly Schnell. 2024. "The Impacts of Physician Payments on Patient Access, Use, and Health." *American Economic Journal: Applied Economics* 16, no. 3 (July): 142–77. https://doi.org/10.1257/app.20210227.

Allen, Heidi, Sarah H. Gordon, Dennis Lee, Aditi Bhanja, and Benjamin D. Sommers. 2021. "Comparison of Utilization, Costs, and Quality of Medicaid vs Subsidized Private Health Insurance for Low-Income Adults." *JAMA Network Open* 4, no. 1: e2032669. https://doi.org/10.1001/jamanetworkopen.2020.32669.

Applied Policy. 2024. "The Medicaid DSH Program." *Applied Policy* (blog), April 2. https://www.appliedpolicy.com/the-medicaid-dsh-program/.

Baicker, Katherine, and Douglas Staiger. 2005. "Fiscal Shenanigans, Targeted Federal Health Care Funds, and Patient Mortality." *Quarterly Journal of Economics* 120, no. 1 (February): 345–86. https://doi.org/10.1162/0033553053327461.

Bailey, Martha J., and Andrew Goodman-Bacon. 2015. "The War on Poverty's Experiment in Public Medicine: Community Health Centers and the Mortality of Older Americans." *American Economic Review* 105, no. 3 (March): 1067–104. https://doi.org/10.1257/aer.20120070.

Baumrucker, Evelyne P., Sarah K. Braun, Alison Mitchell, Angela Napili, and Varun Saraswathula. 2025. *Medicaid: An Overview*. Report no. R43357. Congressional Research Service, April 30. https://www.congress.gov/crs-product/R43357.

Besanko, David, David Dranove, and Craig Garthwaite. 2020. "Insurance Access and Demand Response: Pricing and Welfare Implications." *Journal of Health Economics* 73 (September): 102329. https://doi.org/10.1016/j.jhealeco.2020.102329.

Bradford, Kate, and Kathryn Costanza. 2023. "Medicaid Managed Care 101." National Conference of State Legislators, updated September 21. https://www.ncsl.org/health/medicaid-managed-care-101.

Brown, David W., Amanda E. Kowalski, and Ithai Z. Lurie. 2020. "Long-Term Impacts of Childhood Medicaid Expansions on Outcomes in Adulthood." *Review of Economic Studies* 87, no. 2 (March): 792–821. https://doi.org/10.1093/restud/rdz039.

Bundorf, M. Kate, and Daniel P. Kessler. 2022. "The Responsiveness of Medicaid Spending to the Federal Subsidy." *National Tax Journal* 75, no. 4 (December): 661–80. https://doi.org/10.1086/721912.

Burns, Alice, Elizabeth Hinton, Robin Rudowitz, and Maiss Mohamed. 2025. "10 Things to Know About Medicaid." *KFF* (blog), February 18. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid/.

Burns, Alice, and Benjamin Layton. 2018. *Exploring the Growth of Medicaid Managed Care*. Congressional Budget Office, August 7. https://www.cbo.gov/publication/54235.

Cabral, Marika, Colleen Carey, and Sarah Miller. 2025. "The Impact of Provider Payments on Health Care Utilization of Low-Income Individuals: Evidence from Medicare and Medicaid." *American Economic Journal: Economic Policy* 17, no. 1 (February): 106–43. https://doi.org/10.1257/pol.20220775.

Center for Disease Control (CDC). 2024. "NHIS Health Insurance Data." National Health Interview Survey, November 21. https://www.cdc.gov/nchs/nhis/health-insurance/index.html.

Chandra, Amitabh, Evan Flack, and Ziad Obermeyer. 2021. "The Health Costs of Cost-Sharing." Working paper no. 28439. National Bureau of Economic Research, February; revised February 2024. https://doi.org/10.3386/w28439.

"Community Health Center Chartbook 2024: Analysis of 2022 UDS Data." n.d. *NACHC* (blog). Accessed June 23, 2025. https://www.nachc.org/resource/community-health-center-chartbook/.

Congressional Budget Office (CBO). 2023. "CBO's Estimate of the Budgetary Effects of H.R. 2811, the Limit, Save, Grow Act of 2023." Congressional Budget Office, April 25. https://www.cbo.gov/publication/59102.

Congressional Budget Office (CBO). 2024. "Limit State Taxes on Health Care Providers." Congressional Budget Office, December 12. https://www.cbo.gov/budget-options/60897.

Cooper Jr., Zack, Joseph J. Doyle, John A. Graves, and Jonathan Gruber. 2022. "Do Higher-Priced Hospitals Deliver Higher-Quality Care?" Working paper no. 29809. National Bureau of Economic Research, February; revised January 2023. https://doi.org/10.3386/w29809.

Currie, Janet, and Jonathan Gruber. 1996. "Saving Babies: The Efficacy and Cost of Recent Changes in the Medicaid Eligibility of Pregnant Women." *Journal of Political Economy* 104, no. 6 (December): 1263–96. https://doi.org/10.1086/262059.

Davis, Caitlin, Lars Peterson, and Andrew Bazemore. 2023. "Healthcare Workforce Implications of Physician Student Loan Repayment Funding." *Annals of Family Medicine* 21: 4221.

Doyle, Joseph, John Graves, Jonathan Gruber, and Samuel Kleiner. 2015. "Measuring Returns to Hospital Care: Evidence from Ambulance Referral Patterns." *Journal of Political Economy* 123. no. 1 (February): 170–214. https://doi.org/10.1086/677756.

Dranove, David, Craig Garthwaite, and Christopher Ody. 2016. "Uncompensated Care Decreased at Hospitals in Medicaid Expansion States but Not at Hospitals in Nonexpansion States." *Health Affairs* (Project Hope) 35, no. 8 (August): 1471–79. https://doi.org/10.1377/hlthaff.2015.1344.

Duggan, Mark, and Tamara Hayford. 2013. "Has the Shift to Managed Care Reduced Medicaid Expenditures? Evidence from State and Local-Level Mandates." *Journal of Policy Analysis and Management* 32, no. 3: 505–35. https://doi.org/10.1002/pam.21693.

Dunn, Abe, Joshua D. Gottlieb, Adam Hale Shapiro, Daniel J. Sonnenstuhl, and Pietro Tebaldi. 2024. "A Denial a Day Keeps the Doctor Away." *Quarterly Journal of Economics* 139, no. 1 (February): 187–233. https://doi.org/10.1093/qje/qjad035.

Einav, Liran, and Amy Finkelstein. 2023. *We've Got You Covered: Rebooting American Health Care*. Portfolio/Penguin.

Finkelstein, Amy, Nathaniel Hendren, and Erzo F. P. Luttmer. 2019. "The Value of Medicaid: Interpreting Results from the Oregon Health Insurance Experiment." *Journal of Political Economy* 127, no. 6 (December): 2836–74. https://doi.org/10.1086/702238.

Finkelstein, Amy, and Matthew Notowidigdo. 2019. "Take-Up and Targeting: Experimental Evidence from SNAP." *Quarterly Journal of Economics* 134, no. 3: 1505–56.

Finkelstein, Amy, Sarah Taubman, Bill Wright, Mira Bernstein, Jonathan Gruber, Joseph P. Newhouse, et al. 2012. "The Oregon Health Insurance Experiment: Evidence from the First Year." *Quarterly Journal of Economics* 127, no. 3 (August): 1057–106. https://doi.org/10.1093/qje/qjs020.

Garthwaite, Craig, Tal Gross, and Matthew J. Notowidigdo. 2018. "Hospitals as Insurers of Last Resort." *American Economic Journal: Applied Economics* 10, no. 1: 1–39. https://doi.org/10.1257/app.20150581.

Garthwaite, Craig, Christopher Ody, and Amanda Starc. 2022. "Endogenous Quality Investments in the U.S. Hospital Market." *Journal of Health Economics* 84 (July): 102636. https://doi.org/10.1016/j.jhealeco.2022.102636.

Geruso, Michael, Timothy J. Layton, and Jacob Wallace. 2023. "What Difference Does a Health Plan Make? Evidence from Random Plan Assignment in Medicaid." *American Economic Journal: Applied Economics* 15, no. 3: 341–79. https://doi.org/10.1257/app.20210843.

Geruso, Michael, Neale Mahoney, and Daniel Posthumus. 2025. "Cutting Medicaid Is a Risky Move for Republicans." *Briefing Book*, April 14. https://www.briefingbook.info/p/cutting-medicaid-is-a-risky-move.

Gottlieb, Joshua D., Adam Hale Shapiro, and Abe Dunn. 2018. "The Complexity of Billing and Paying for Physician Care." *Health Affairs* 37, no. 4 (April): 619–26. https://doi.org/10.1377/hlthaff.2017.1325.

Gray, Colin, Adam Leive, Elena Prager, Kelsey Pukelis, and Mary Zaki. 2023. "Employed in a SNAP? The Impact of Work Requirements on Program Participation and Labor Supply." *American Economic Journal: Economic Policy* 15, no. 1 (February): 306–41. https://doi.org/10.1257/pol.20200561.

Hest, Robert. 2022. "Assessing Physician Acceptance of Medicaid Patients Using State Health Compare." State Health Access Data Assistance Center, August 25. https://www.shadac.org/news/14-17-physician-Mcaid-SHC.

Hu, Luojia, Robert Kaestner, Bhashkar Mazumder, Sarah Miller, and Ashley Wong. 2018. "The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing." *Journal of Public Economics* 163 (July): 99–112. https://doi.org/10.1016/j.jpubeco.2018.04.009.

Kaiser Family Foundation (KFF). n.d.a. "Medicaid-to-Medicare Fee Index." *KFF* (blog). Accessed June 23, 2025. https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/.

Kaiser Family Foundation (KFF). n.d.b. "Total Medicaid Spending." n.d. *KFF* (blog). Accessed June 23, 2025. https://www.kff.org/medicaid/state-indicator/total-medicaid-spending/.

Kaiser Family Foundation (KFF). 2025. "Medicaid Enrollment and Unwinding Tracker: Enrollment Data." *KFF* (blog), June 2. https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-enrollment-data/.

Klein, Ezra, and Derek Thompson. 2025. *Abundance*. Simon and Schuster.

Klemm, John D. 2000. "Medicaid Spending: A Brief History." *Health Care Financing Review* 22, no. 1 (Fall): 105–12. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/00fallpg105.pdf.

Kluender, Raymond, Neale Mahoney, Francis Wong, and Wesley Yin. 2025. "The Effects of Medical Debt Relief: Evidence from Two Randomized Experiments." *Quarterly Journal of Economics* 140, no. 2 (May): 1187–241. https://doi.org/10.1093/qje/qjae045.

Layton, Timothy J., Nicole Maestas, Daniel Prinz, and Boris Vabson. 2019. "Private vs. Public Provision of Social Insurance: Evidence from Medicaid." Working paper no. 26042. National Bureau of Economic Research, July. https://doi.org/10.3386/w26042.

Layton, Timothy J., Nicole Maestas, Daniel Prinz, and Boris Vabson. 2022. "Health Care Rationing in Public Insurance Programs: Evidence from Medicaid." *American Economic Journal: Economic Policy* 14, no. 4: 397–431. https://doi.org/10.1257/pol.20190628.

Layton, Timothy, and Eran Politzer. 2024. "The Dynamic Fiscal Costs of Outsourcing Health Insurance—Evidence from Medicaid." Working paper no. 33302. National Bureau of Economic Research, December. https://doi.org/10.3386/w33302.

Li, Bohan, and Timothy Layton. 2025. "Medicaid Managed Care: Substantial Shifts in Market Landscape and Acquisitions, 2006–2020." *Health Affairs (Project Hope)* 44, no. 7.

Lo Sasso, Anthony T., and Gayle R. Byck. 2010. "Funding Growth Drives Community Health Center Services." *Health Affairs (Project Hope)* 29, no. 2 (February): 289–96. https://doi.org/10.1377/hlthaff.2008.0265.

Mahoney, Neale. 2015. "Bankruptcy as Implicit Health Insurance." *American Economic Review* 105, no. 2 (February): 710–46. https://doi.org/10.1257/aer.20131408.

Mansell, Lawson. 2024. "Healthcare Abundance: An Agenda to Strengthen Healthcare Supply." Niskanen Center, October. https://www.niskanencenter.org/healthcare-abundance-an-agenda-to-strengthen-healthcare-supply/.

McGough, Matthew, Emma Wager, Aubrey Winger, Nirmita Panchal, and Lynne Cotter. 2024. "How Has U.S. Spending on Healthcare Changed over Time?" *Health System Tracker,* December 20. https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/.

McMichael, Benjamin J. 2023. "Supply-Side Health Policy: The Impact of Scope-of-Practice Laws on Mortality." *Journal of Public Economics* 222 (June): 104901. https://doi.org/10.1016/j.jpubeco.2023.104901.

McMorrow, Stacey, and Stephen Zuckerman. 2014. "Expanding Federal Funding to Community Health Centers Slows Decline in Access for Low-Income Adults." *Health Services Research* 49, no. 3 (June): 992–1010.

Medicaid and CHIP Payment and Access Commission (MACPAC). n.d.a. "MACStats." Medicaid and CHIP Payment and Access Commission. Accessed June 23, 2025. https://www.macpac.gov/macstats/.

Medicaid and CHIP Payment and Access Commission (MACPAC). n.d.b. "Managed Care." Medicaid and CHIP Payment and Access Commission. Accessed June 23, 2025. https://www.macpac.gov/topic/managed-care/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015. "Exhibit 8: Medicaid Enrollment and Spending, FYs 1970–2020." In *MACStats: Medicaid and CHIP Data Book*, 25. Medicaid and CHIP Payment and Access Commission, December. https://www.macpac.gov/wp-content/uploads/2020/07/MACStats-Medicaid-and-CHIP-Data-Book-December-2015.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021. "Physician Acceptance of New Medicaid Patients: Findings from the National Electronic Health Records Survey." Medicaid and CHIP Payment and Access Commission fact sheet, June. https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf.

Miller, Sarah, Norman Johnson, and Laura R. Wherry. 2021. "Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data." *Quarterly Journal of Economics* 136, no. 3 (August): 1783–829. https://doi.org/10.1093/qje/qjab004.

Miller, Sarah, and Laura R. Wherry. 2019. "The Long-Term Effects of Early Life Medicaid Coverage." *Journal of Human Resources* 54, no. 3 (July): 785–824. https://doi.org/10.3368/jhr.54.3.0816.8173R1.

Mitchell, Alison. 2023 *Medicaid Disproportionate Share Hospital Payments*. Report no. R42865. Congressional Research Service, November 20. https://www.congress.gov/crs-product/R42865.

Montoya, Daniela Franco, Puneet Kaur Chehal, and E. Kathleen Adams. 2020. "Medicaid Managed Care's Effects on Costs, Access, and Quality: An Update." *Annual Review of Public Health* 41 (April): 537–49. https://doi.org/10.1146/annurev-publhealth-040119-094345.

Myong, Catherine, Peter Hull, Mary Price, John Hsu, Joseph P. Newhouse, and Vicki Fung. 2020. "The Impact of Funding for Federally Qualified Health Centers on Utilization and Emergency Department Visits in Massachusetts." *PloS One* 15, no. 12 (December): e0243279. https://doi.org/10.1371/journal.pone.0243279.

Nikpay, Sayeh S., Melinda B. Buntin, and Rena M. Conti. 2020. "Relationship Between Initiation of 340B Participation and Hospital Safety-Net Engagement." *Health Services Research* 55, no. 2 (March): 157–69. https://doi.org/10.1111/1475-6773.13278.

Nocon, Robert S., Sang Mee Lee, Ravi Sharma, Quyen Ngo-Metzger, Dana B. Mukamel, Yue Gao, et al. 2016. "Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings." *American Journal of Public Health* 106, no. 11: 1981–89. https://doi.org/10.2105/AJPH.2016.303341.

Oostrom, Tamar, Liran Einav, and Amy Finkelstein. 2017. "Outpatient Office Wait Times and Quality of Care for Medicaid Patients." *Health Affairs* 36, no. 5.

Paradise, Julia, Barbara Lyons, and Diane Rowland. 2015. "Low-Income Pregnant Women, Children and Families, and Childless Adults." In *Medicaid at 50. KFF,* May 6. https://www.kff.org/report-section/medicaid-at-50-low-income-pregnant-women-children-and-families-and-childless-adults/.

Perez, Victoria. 2018. "Does Capitated Managed Care Affect Budget Predictability? Evidence from Medicaid Programs." *International Journal of Health Economics and Management* 18, no. 2: 123–52. https://doi.org/10.1007/s10754-017-9227-7.

Perkins, Jane. 2013. "Fact Sheet: The Supreme Court's ACA Decision and Its Implications for Medicaid." *National Health Law Program* (blog), April 15. https://healthlaw.org/resource/fact-sheet-the-supreme-courts-aca-decision-its-implications-for-medicaid/?issue_area=public-health.

Peter G. Peterson Foundation. 2024. "Three Key Things to Know about CHIP." *PGPF.org*, last updated December 23. https://www.pgpf.org/article/three-key-things-to-know-about-chip/.

Polsky, Daniel, Michael Richards, Simon Basseyn, Douglas Wissoker, Genevieve Kenney, Stephen Zuckerman, et al.. 2015. "Appointment Availability After Increases in Medicaid Payments for Primary Care." *New England Journal of Medicine* 372, no. 6: 537–45.

Robezniek, Andis. 2019. "Medicare-Only Oak Street Health Isn't Shy About Taking Big Risks." American Medical Association, July 23. https://www.ama-assn.org/practice-management/payment-delivery-models/medicare-only-oak-street-health-isn-t-shy-about-taking.

Rudowitz, Robin, Jennifer Tolbert, Alice Burns, Elizabeth Hinton, and Anna Mudumala. 2024. "Medicaid 101." In *Health Policy* 101, edited by Drew Altman. KFF (blog), May 28. https://www.kff.org/health-policy-101-medicaid/.

Sanger-Katz, Margot, and Sarah Kliff. 2025. "G.O.P. Targets a Medicaid Loophole Used by 49 States to Grab Federal Money." *New York Times,* May 6. https://www.nytimes.com/2025/05/06/upshot/medicaid-hospitals-republicans-cuts.html.

Sigritz, Brian, Kathryn White, and Leah Wavrunek. 2024. *2024 State Expenditure Report*. National Association of State Budget Officers. https://www.nasbo.org/reports-data/state-expenditure-report.

Sommers, Benjamin, Katherine Baicker, and Arnold Epstein. 2012. "Mortality and Access to Care Among Adults After State Medicaid Expansions." *New England Journal of Medicine*, vol. 367: 1025–34.

Sommers, Benjamin, Anna Goldman, Robert Blendon, John Orav, and Arnold Epstein. 2019. "Medicaid Work Requirements—Results from the First Year in Arkansas." *New England Journal of Medicine* 381, no. 11: 1073–82.

Sparer, Michael. 2012. *Medicaid Managed Care: Costs, Access, and Quality of Care.* Robert Wood Johnson Foundation. https://catalog.nlm.nih.gov/discovery/fulldisplay/alma9915989403406676/01NLM_INST:01NLM_INST.

US Government Accountability Office. 2024. *Health Centers: Revenue, Grant Funding, and Methods for Meeting Certain Access-to-Care Requirements.* Report no. GAO-24-106815. Government Accountability Office, March 7. https://www.gao.gov/products/gao-24-106815.

Weiss, A. J., G. Pickens, and M. Roemer. 2021. *Methods for Calculating Patient Travel Distance to Hospital in HCUP Data*. HCUP Methods Series report no. 2021-02. US Agency for Healthcare Research and Quality, December 6. www.hcup-us.ahrq.gov/reports/methods/methods.jsp.

Wherry, Laura R., and Bruce D. Meyer. 2016. "Saving Teens: Using a Policy Discontinuity to Estimate the Effects of Medicaid Eligibility." *Journal of Human Resources* 51, no. 3 (August): 556–88. https://doi.org/10.3368/jhr.51.3.0913-5918R1.

Wherry, Laura R., Sarah Miller, Robert Kaestner, and Bruce D. Meyer. 2018. "Childhood Medicaid Coverage and Later-Life Health Care Utilization." *Review of Economics and Statistics 100*, no. 2 (May): 287–302. https://direct.mit.edu/rest/article-abstract/100/2/287/58444/Childhood-Medicaid-Coverage-and-Later-Life-Health.

Williams, Elizabeth, Alice Burns, Rhiannon Euhus, and Robin Rudowitz. 2025. "Eliminating the Medicaid Expansion Federal Match Rate: State-by-State Estimates." *KFF* (blog), February 13. https://www.kff.org/medicaid/issue-brief/eliminating-the-medicaid-expansion-federal-match-rate-state-by-state-estimates/.

Wyse, Angela, and Bruce D. Meyer. 2025. "Saved by Medicaid: New Evidence on Health Insurance and Mortality from the Universe of Low-Income Adults." Working paper no. 33719. National Bureau of Economic Research, May. https://www.nber.org/papers/w33719.

Yglesias, Matthew. 2021. "Homelessness Is About Housing." *Slow Boring* (blog), May 17. https://www.slowboring.com/p/homelessness-housing.