Federalism and Health Care: Lessons from State Policies on Immigrants' Eligibility for Medicaid

Author : Jessica Lind Mantel

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The allocation of public health authority in the United States across more than 2,000 federal, state and local government departments has produced a decentralized, disjointed response to the novel coronavirus disease 2019 (COVID-19). The COVID-19 pandemic also lays bare the vast inequalities in health based on race, ethnicity, and income, and how limited access to health care for some can adversely impact the many. This has brought increased attention to our federalist form of government and the merits of dividing power in the health care arena between a national government and states. Broader health care reform debates about the Affordable Care Act, a public health insurance option, and single payor raise similar questions about federalism's role in health policy.

Medha Makhlouf's forthcoming article, Laboratories of Exclusion: Medicaid, Federalism & Immigrants, adds an important and timely contribution to this discussion by providing an in-depth study of federalism's role in shaping state policies on immigrant eligibility for Medicaid. The article shows how Medicaid's cooperative federalism structure has not only failed to produce one of the cited benefits of federalism ? better policy outcomes from state experimentation and innovation ? but has encouraged the opposite ? policies that favor the exclusion of immigrants from Medicaid and weaken national health policy goals. Moreover, the article shows how federalism can frustrate national policies that seek greater health equity and even exacerbate existing health inequalities.

The Article begins with a history of immigrant eligibility for Medicaid and explains its evolution to a federal framework that gives states considerable discretion to create policies on noncitizen eligibility for Medicaid. It then documents states' wide-ranging responses under this framework. The availability of federal matching funds has enticed most states to expand coverage to lawfully present noncitizens with long-term residence (at least 5 years) and who therefore have secure pathways to citizenship. The picture is more mixed with respect to state responses to federal matching funds for other noncitizens. Some states have used available federal funds to expand Medicaid eligibility to some noncitizens, suggesting that federal funding can nudge states toward more expansive policies. Yet ideology and fiscal constraints have caused many states to forego using federal matching funds to expand coverage to other noncitizens, including children and pregnant women. Moreover, perhaps not surprisingly, very few states have elected to use state-only funds to expand coverage to undocumented immigrants, and those that have done so often adopt narrow eligibility criteria and coverage limits due to limited state budgets.

In Part II, Professor Makhlouf highlights the problems of an existing patchwork of state policies on immigrant eligibility for Medicaid that favor exclusion. After explaining how these policies reinforce health disparities among citizens and noncitizens, she discusses the public health risks and inefficiencies these policies produce. The rapid spread of COVID-19 presents an all too timely example of the spillover effects of denying noncitizens access to health care, but Professor Maklouf also notes the potential for higher rates of property and violent crimes when noncitizens' behavioral health needs go unmet, the strain on U.S. citizens with noncitizen family members in poor health, and lower productivity among noncitizens in the workforce. In addition, states' exclusionary Medicaid policies create inefficiencies in health care financing, as noncitizens' poorer health from delayed and foregone care leads to unpaid emergency room and hospital care, increased Medicaid emergency funding, higher Medicaid and Medicare disproportionate hospital (DSH) payments, and cost-shifting. The Article also argues that these state policies frustrate health equity goals and illustrates the link between growing racial and ethnic diversity among noncitizens and the

decreasing generosity of state social policies.

Parts III and IV situate the Article's case study in the larger literature on federalism, and in particular legal commentators' arguments over the strength and weaknesses of federalism in the health policy arena. Professor Makhlouf shows that rather than enable better policy outcomes through laboratories of democracy, the federalism framework for noncitizen Medicaid eligibility has produced a race to the bottom. This results in part from racial and ethnic dynamics operating at the state level that lead to exclusionary policies and greater health inequities. Fiscal constraints also prevent states from embracing federal options, either because of poor baseline economic conditions or concerns that a future downturn would make it difficult to continue state support for expansive Medicaid policies. Moreover, as the Article explains, various structural features of federalism reinforce these challenges. First, federal law requires affirmative legislative action at the state level that authorizes the expansion of Medicaid to certain groups of noncitizens. Second, siloed state-level advocacy makes it harder for organizations to advance greater health equity across states. These are important lessons for those calling for heath reforms that promote universal access and reduce health disparities.

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