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Medicaid: Supporting the Economy and Middle Class Since 1965

Item Type	Bicameral Minority Staff Report
Download date	2026-03-05 23:04:16
Link to Item	https://hdl.handle.net/20.500.14300/3456

Medicaid: Supporting the Economy and Middle Class Since 1965

May 2018



JOINT ECONOMIC COMMITTEE
DEMOCRATS

U.S. Senator Martin Heinrich
Ranking Member

Medicaid: Supporting the Economy and Middle Class Since 1965

Before Medicaid, many Americans couldn't afford the care they needed. For more than 50 years, the Medicaid program has guaranteed access to comprehensive health insurance for millions of people, providing coverage to over 72 million beneficiaries today.¹ In doing so, Medicaid has bolstered the U.S. economy and provided an important backstop to the country's economic security.²

There are clear health benefits to providing health care to those who wouldn't otherwise be able to afford it. In 1963, prior to the program, only 56 percent of people from low-income families saw a physician, compared to 71 percent from high-income families. By 1970, that gap substantially improved, with 65 percent of poor families seeing a physician.³ But the benefits of the Medicaid program go beyond just health care. In many ways, the Medicaid program supports our nation's economy by strengthening economic security for low- and middle-income families, including providing critical long-term care for older Americans and people with disabilities.

However, the Trump administration and Republicans in Congress are undermining the Medicaid program. Under the guise of reform, Republicans are proposing to end Medicaid's guarantee of affordable, comprehensive coverage. Their proposals would kick millions of enrollees off the program through draconian caps and block grants, and greenlight burdensome and harmful eligibility restrictions like work requirements and lock-out periods. Today, nearly a quarter of the nonelderly population is covered by Medicaid,⁴ many of whom would not be able to afford health care without the program. Continuing Medicaid's legacy in helping low- and middle-income families protect their health and financial security is critical to growing our economy and the middle class.

Shores up Family Finances

Medicaid helps relieve the burden of rising health care costs on family budgets so that families are not forced to choose between health care and other daily necessities. Evidence from Oregon's Medicaid experiment in 2008 shows that receiving Medicaid reduced the likelihood of having to borrow money or skip paying bills by more than 50 percent.⁵

Low-income households without Medicaid also spend significantly more of their budgets on health care than those with Medicaid: In 2014, health care accounted for 6 percent of spending in non-Medicaid households compared to just 1 percent among Medicaid households.⁶ If Medicaid households spent a similar share of their spending on health care as low-income non-Medicaid households, they would have an additional \$1,400 extra a year for other necessities, on average.⁷

The Affordable Care Act’s (ACA) Medicaid expansion has reduced the pressures of medical debt. It decreased the amount of debt sent to collectors, with one study estimating a decrease of about \$1,140 among newly eligible Medicaid enrollees.⁸ Other research has shown that the expansion reduced aggregate unpaid medical bills by \$3.4 billion in the first two years and improved credit scores.⁹

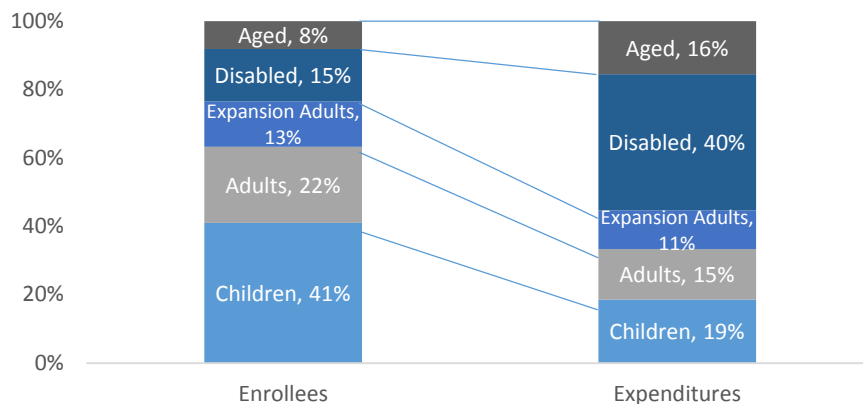
Medicaid also helps family finances by supporting beneficiaries’ ability to work. Contrary to claims that Medicaid coverage discourages individuals from seeking work, research shows that Medicaid expansion can promote employment by making it easier for employed workers to keep working and for unemployed enrollees to look for work.¹⁰

Provides Economic Security by Supporting Long-Term Care

As the elderly make up an increasing share of the U.S. population, many seniors and their families struggle to afford the long-term services and supports they need, particularly because Medicare covers limited long-term care services. This means many seniors end up relying on Medicaid to access nursing home care and home- and community-based services.

Medicaid plays an important role for both low- and middle-income seniors, covering more than half of all long-term care payments. Medicaid expenditures are disproportionately high for people with disabilities and seniors, who together account for 56 percent of Medicaid expenditures (see below). For seniors who receive full Medicaid benefits, long-term care accounts for nearly 70 percent of their benefits in 2011.¹¹ Today, a nursing home typically costs over \$91,000 a year and home health aides almost \$46,000 annually. Medicaid eases the burden on the chronically ill, playing a prominent role in keeping these people out of poverty.

Enrollment and Expenditures by Enrollment Group



Source: Centers for Medicare & Medicaid, 2016 Medicaid Actuarial Report on the Financial Outlook for Medicaid
 Note: Data is for FY 2015.

A substantial portion of seniors become eligible for Medicaid services as they age and spend down their assets. Over a period of 10 years, nearly 10 percent of people age 50 or older spent down into Medicaid, comprising nearly two-thirds of everyone age 50 or older who became eligible for Medicaid during this time. About half of those who spent down use long-term services and supports. Although many of those who spend down are fairly close to being eligible to begin with, over 10 percent of people of all ages making between \$32,000 and \$61,000 spend down into Medicaid.¹²

Fights Poverty

Medicaid plays an important role in fighting poverty by helping families afford the care they need. The enactment of the Social Security Act of 1965, which established Medicaid and Medicare, was accompanied by a near halving of the nonelderly poverty rate.¹⁴ In 2010, Medicaid was estimated to lift between 2.1 and 3.4 million people out of poverty.¹⁵ This makes Medicaid the United States' third largest anti-poverty program and an essential safety net that helps families secure a path toward the middle class.

Medicaid and Public Health Emergencies

Medicaid is uniquely situated to respond to public health emergencies given its federal matching funding mechanism. Throughout its history, Medicaid has been able to provide emergency funding to public health crises like the HIV/AIDS epidemics, the 2001 World Trade Center attacks, Hurricane Katrina, and the Flint, Michigan lead contamination crisis.¹³ In the face of public emergencies, Medicaid can provide immediate relief even when Congress has to take time to pass emergency funding bills.

For communities of color, Medicaid helps families afford coverage when they can't get access to employer-based insurance. American Indian and Alaska Natives (AIAN), Native Hawaiian and Pacific Islanders (NHPI), and black communities—all communities with high poverty rates—are most likely to be enrolled in Medicaid at roughly 34 percent.¹⁶ Medicaid expansion cut the nonelderly AIAN uninsured rate by a third in expansion states and helped expand revenues and capacity of Indian Health Service and Tribal facilities.¹⁷ In 2010, Medicaid lifted at least 550,000 black Americans and 610,000 Hispanic Americans out of poverty.¹⁸

Supports State Economies

Federal and state Medicaid spending has had a positive impact on state economies and jobs. The funding generates economic activity by supporting both jobs in the health care sector, as well as other facets of the economy.

One study found that in 2001, states spent a combined \$97.7 billion on Medicaid, and the investment generated a nearly three-fold return of \$279.3 billion in increased state economic activity.¹⁹ The same research also showed that Medicaid generated nearly 3 million jobs, with more than \$100 billion in wages. Children who are covered by Medicaid or CHIP also experience

long-term economic gains as adults, resulting in a stronger tax base. Research shows that children who were covered by Medicaid pay more in taxes as adults.²⁰

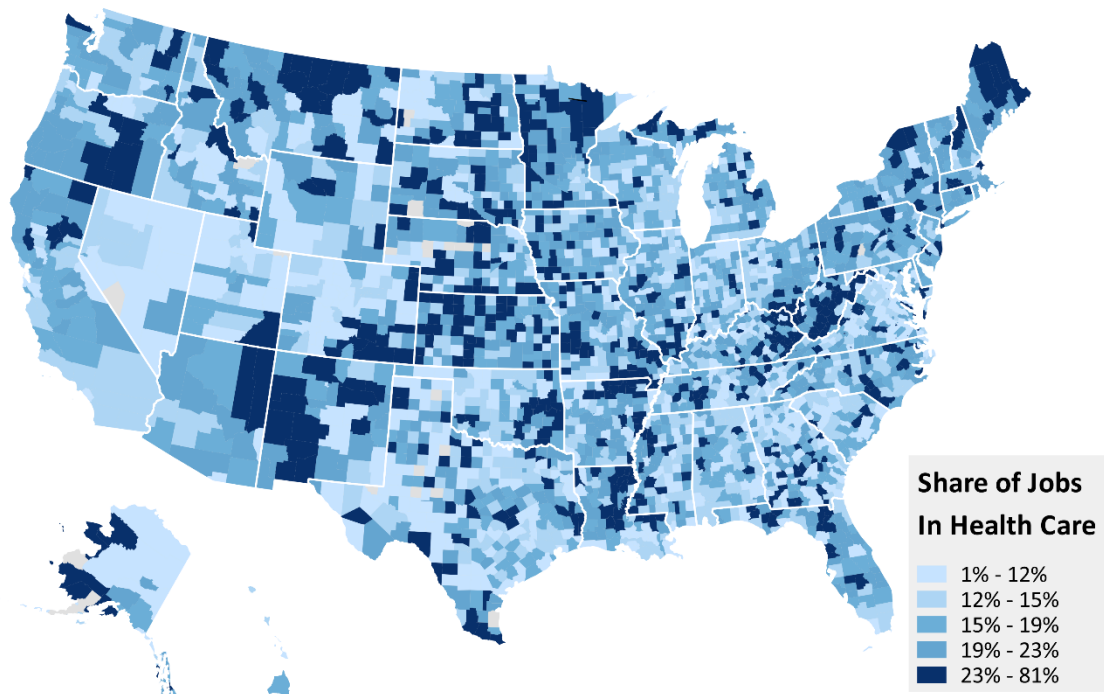
Further, because the program's benefits are concentrated on lower-income populations, it shores up the economy during economic downturns and acts as an automatic stabilizer during times of economic distress. For example, it is estimated that Alabama children's enrollment in Medicaid/CHIP increased by 24 percent in response to the Great Recession.²¹ This increased spending reduced the sharp fall of GDP growth. In 2009, increased federal Medicaid dollars boosted GDP by 0.21 percentage points, a third of which was from Medicaid's role as an automatic stabilizer. Without federal Medicaid spending's contribution, the fall in GDP that year would have been twice as large.²²

Important to Rural Populations and Hospitals

Medicaid has had a particularly positive impact in rural communities and economies. One in four rural Americans depends on Medicaid for health insurance, including 1.7 million people who gained coverage through the Medicaid expansion.²³ Rural Americans in non-expansion states are almost twice as likely to be uninsured compared to those in expansion states.²⁴

Rural hospitals are often engines of economic growth in rural areas.²⁵ More than 40 percent of rural counties in the U.S. rely on hospitals for more than 10 percent of their jobs. These are critical middle-class jobs: On average, rural hospital employees make \$47,000, 43 percent higher than other workers in their counties.²⁶ As of 2016, there are 673 vulnerable rural hospitals in the United States, supporting 99,000 health care jobs in rural communities and \$277 billion in economic activity.²⁷

Share of Employment in Health Care by County



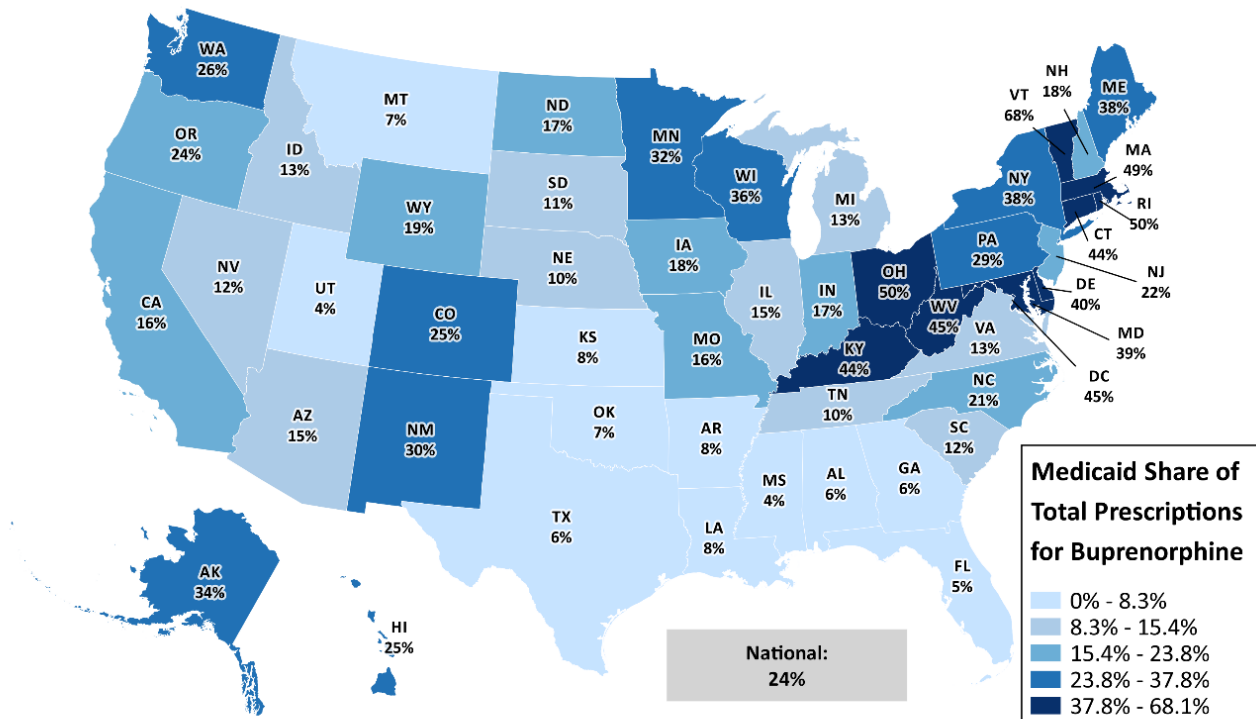
Source: County Business Patterns, 2015

Medicaid expansion has helped stabilize many rural hospitals by curbing uncompensated care costs and increasing coverage. These effects are significant as Medicaid funding makes up more than 10 percent of net revenue in rural hospitals.²⁸ As a result, rural hospitals in Medicaid expansion states improved their operating margins more than non-expansion states.²⁹

Crucial for Mental Health and Substance Abuse

One of the biggest problems facing our economy is the opioids crisis, which has devastated and stifled millions of communities across the country. Medicaid is the strongest tool we have for fighting this national epidemic and getting people back to work. Medicaid is the largest payer for behavioral health and substance use disorder (SUD) services in the country, and nationwide covers one of every three nonelderly Americans battling opioid dependence, and one in four payments for medication-assisted treatment for people with opioid addiction.³⁰

Medicaid Pays for Large Share of Opioid Treatment



Source: IMS Institute for Healthcare Analytics, June 2016 data
 Note: Buprenorphine is used for medication-assisted treatment of opioid addiction.

The ACA’s expansion of the Medicaid program has played a crucial role in fighting the opioid and heroin epidemic. In fact, Medicaid expansion granted 1.3 million people access to behavioral health care services and decreased the unmet need for substance use disorder treatment among low-income adults by 18 percent.³¹ One of three people who gained coverage under Medicaid expansion had a substance use disorder, mental health condition, or both.³² Given that the opioid crisis may be playing a role in low labor force participation, Medicaid’s role in helping people receive treatment is more important than ever in fortifying the economy and the middle class.³³

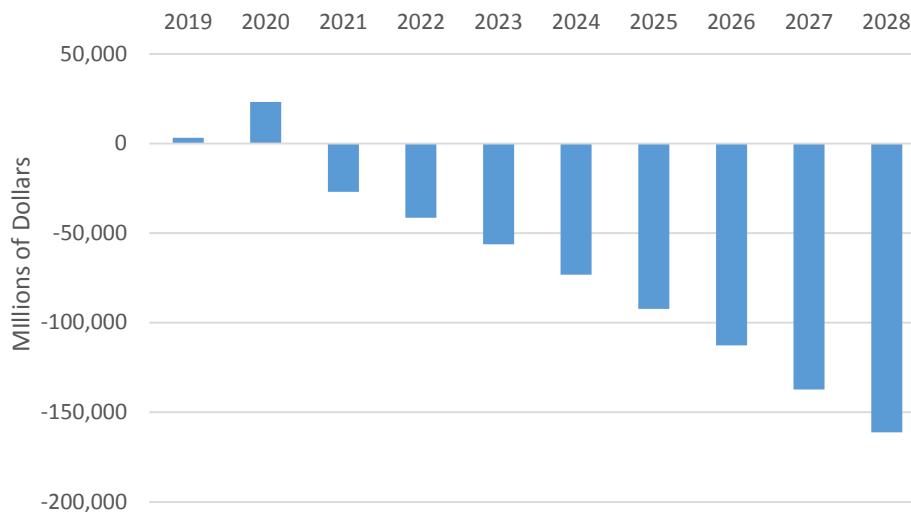
Republican Attacks on Medicaid

Under the guise of reform, Republicans are proposing to drastically cut and dismantle the Medicaid program. Since the beginning of the program, Medicaid has provided a crucial buffer that protects the health and financial security of millions of low- and middle-income families. Today, nearly a quarter of the nonelderly population is covered by Medicaid, and without the program many of them would not have health insurance.

Attacks in Trump Budget

The president's FY 2019 budget proposes to repeal the ACA based on the Graham-Cassidy bill that failed in the Senate last fall. This includes repealing Medicaid expansion and imposing draconian caps on the entire program. It rolls back funding from Medicaid expansion and payments that help Americans afford their health insurance, replacing it with artificial caps that fall short of actual need. These caps would effectively redistribute billions from expansion to non-expansion states while giving states fewer federal dollars overall, making this proposal a raw deal for both beneficiaries and state budgets. Over 10 years, total cuts to health coverage would amount to \$675 billion.³⁴ Further estimates show that over 20 years, similar proposals could slash federal Medicaid funding by up to \$4 trillion because of Graham-Cassidy's funding cliff.³⁵

Trump Budget Cuts \$675B From Medicaid and Related Health Funding Over 10 Years



Source: Office of Management and Budget, FY 2019 President's Budget

These proposals pose serious threats to state budgets and economies.³⁶ Medicaid spending accounts for 28 percent of state budgets, and nearly two-thirds of that is covered by federal Medicaid contributions.³⁷ Imposing caps would force states to choose between covering fewer people, cutting services, reducing provider payments, rolling back other public services and investments, or raising taxes. Such cuts would leave state Medicaid programs unable to adequately deal with present and future public health crises like the opioid crisis.

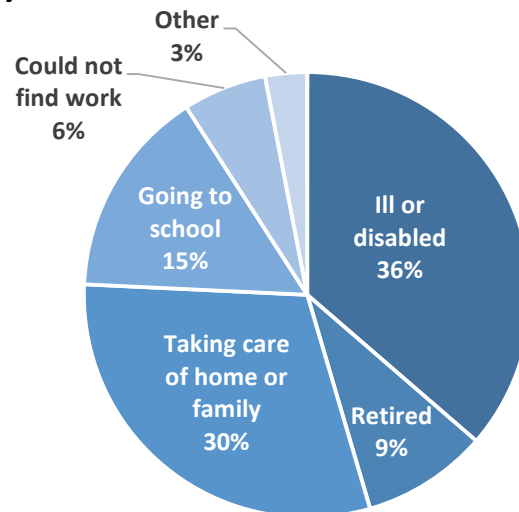
The budget also proposes reinstating asset testing to Medicaid eligibility, which penalizes savings and adds further impediments to critical health coverage for low- and middle-income

families.³⁸ As a result, such restrictions discourage people from building up savings, particularly if they or their family members rely on Medicaid to access needed health care.³⁹

State Waivers

Further actions and proposals masquerading as “improving state flexibility” threaten to severely cut eligibility and benefits. This year, the administration took the unprecedented step of allowing states like Kentucky, Indiana, and Arkansas to implement work requirements and other harmful eligibility restrictions as part of their Medicaid programs.

Why Adult Medicaid Enrollees Aren't Working



Source: Kaiser Family Foundation analysis of 2017 CPS ASEC
Note: Includes nonelderly adults who do not receive Supplemental Security Insurance

The evidence shows that work requirements do not increase employment among those already struggling to find work and have little overall effect on employment in the long term.⁴⁰ Most Medicaid recipients who can work already do—60 percent of adults on Medicaid are working.⁴¹ Of those not working, more than half are family caregivers, in school, ill, or disabled.⁴²

Further, beneficiaries who are unemployed often have chronic or incapacitating conditions that make work impossible.⁴³ In fact, nearly half of Medicaid expansion adults are permanently disabled, have physical or cognitive limitations after experiencing cancer, diabetes, or other conditions, or are generally in fair or poor health.⁴⁴ As a result, tying Medicaid eligibility to employment does little to help these individuals secure work, and more frequently threatens their ability to continue accessing the benefits and services they and their families depend on.

The administration has also encouraged states to adopt other harmful, burdensome eligibility restrictions on their Medicaid programs, including lock-out periods as well as onerous premiums and cost sharing—all of which threaten access to essential health care for millions of people.⁴⁵

Looking Forward

The Medicaid program is a critical part of our health care system, ensuring that low- and middle-income Americans can get access to the care they need and contribute to a vibrant economy. Medicaid is the third largest anti-poverty program, lifting at least 2.6 million people out of poverty each year.⁴⁶ It helps to shore up family finances for all of its over 72 million beneficiaries, paying for needed long-term care for seniors and people with disabilities and helping individuals stay healthy enough to keep working or seek employment.

Medicaid and Medicaid expansion support jobs in communities nationwide, including in rural communities where local hospitals are the largest employer in town. They also provide some relief for those who see their incomes hit during recessions and help cushion the overall economy during downturns. Additionally, those struggling with mental health and substance use disorders, including those afflicted by the opioid epidemic, depend on Medicaid to pay for life-saving treatment.

Yet, Republicans continue to try to pull the rug out from under the millions of women, children, seniors, people with disabilities, and others who depend on this critical program. Despite failing in their attempts to gut Medicaid through TrumpCare, the Trump administration has continued to call for the same failed ideas in its proposed FY2019 budget. Even more worrisome, it has continued to sabotage the program by encouraging state waiver policies that burden beneficiaries with additional red tape and threaten to block people from the essential health services they need.

Medicaid Evolves Over 50 Years to Meet Changing Needs

Starting in 1965, Medicaid gave states the option of federal funding for states to provide care for low-income children and their parents, people with disabilities, and low-income seniors for services not covered by Medicare. It provides a lot of flexibility to states, which can set their own funding levels with the federal government paying on average 63 percent of a state's Medicaid budget.⁴⁷

Expansion

Until recently, Medicaid was mostly limited to low-income children, mothers, seniors, and individuals with disabilities, leaving a swath of low-income adults without coverage. The ACA allowed states to expand coverage to anyone who falls below 138 percent of the Federal Poverty Level (FPL), including childless adults.⁴⁸ By 2016, nearly 12 million newly eligible enrollees had health insurance coverage thanks to Medicaid expansion.⁴⁹

Pregnant Women and Children

Since the early years of Medicaid, the program has offered significant benefits for children, providing comprehensive care and screenings to children up to age 21. In 1989, Congress mandated that states cover all pregnant women and children up to age six who were at or below 133 percent of the FPL, greatly expanding eligibility for these vulnerable populations.⁵⁰ By 2002, Medicaid covered all children aged 18 and under nationwide who lived in poverty.⁵¹ With the addition of the Children's Health Insurance Program (CHIP) in 1997, states were able to further expand coverage for children in families up to 200 percent of the FPL, above the existing Medicaid cutoff. CHIP provided the means for states to expand health care coverage to children whose families made too much to qualify for Medicaid but could not afford private insurance. As a result, CHIP filled a critical gap in coverage for children in low- and middle-income families.⁵²

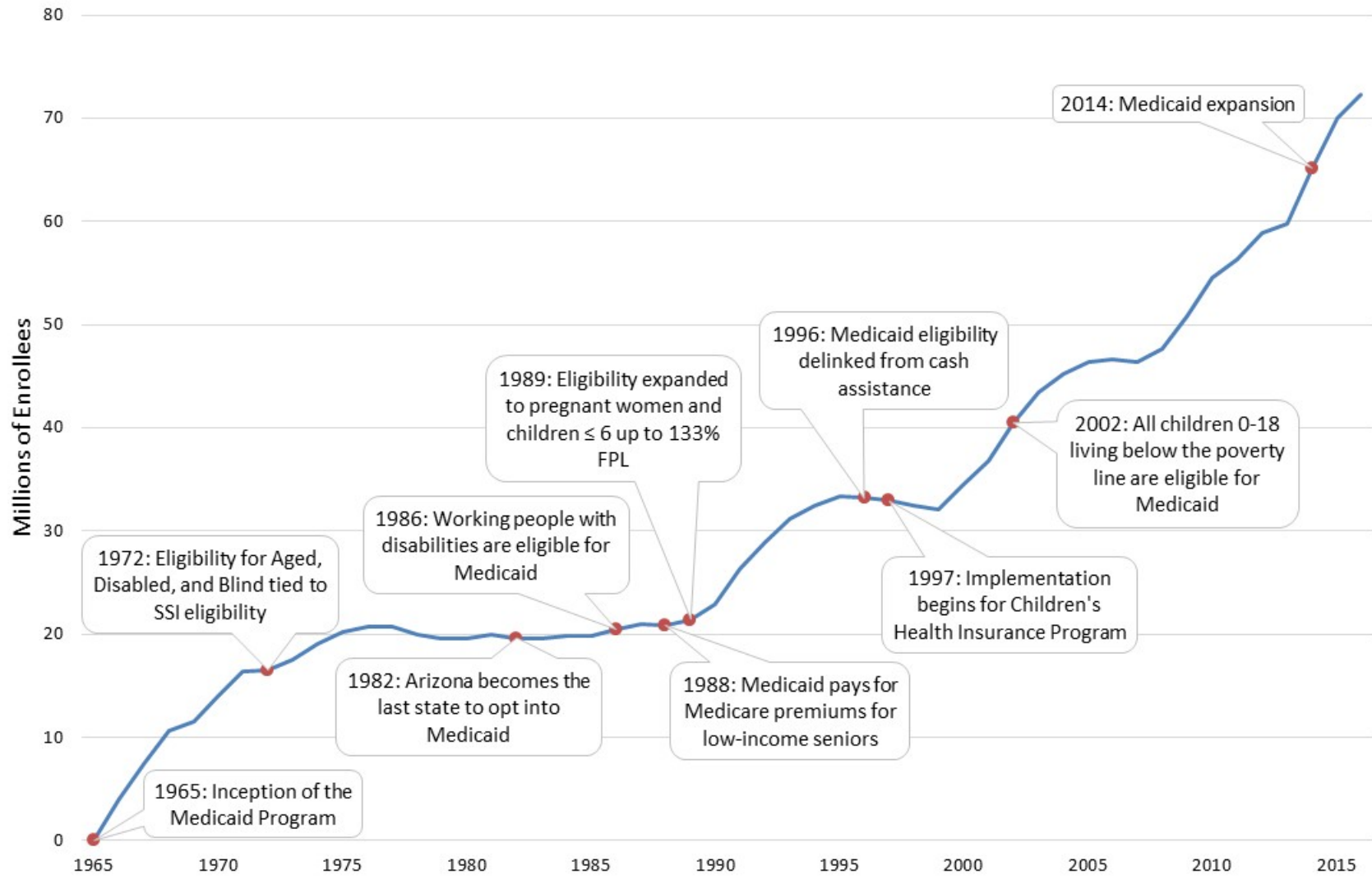
People with Disabilities

In 1972, Medicaid eligibility was extended to anyone who received Supplemental Security Income (SSI), a federal program for the aged, blind, and people with disabilities who are low-income.⁵³ This created a floor below which all seniors, blind, and people with disabilities would be eligible for Medicaid, which was roughly 74 percent of the FPL. Unlike former state-based cash assistance eligibility levels, which were often fixed dollar amounts, linking Medicaid to SSI eligibility also ensured that eligibility levels were inflation adjusted.⁵⁴ Along with the SSI reforms, the Social Security Disability Insurance program (SSDI) solidified Medicaid's role as a provider of long-term care services. Today, Medicaid is the primary payer for long-term services and supports in the nation.

Elderly

In addition to the major expansions in health coverage for the elderly thanks to Medicare, Medicaid also supports many low-income elderly persons whose Medicare benefits do not cover all of their needs. The 1972 SSI reforms strengthened Medicaid's role as a stopgap coverage for low-income seniors. And in 1988, Congress required state Medicaid programs to pay the Medicare premiums for elderly beneficiaries falling below the FPL.⁵⁵ The most important way that Medicaid serves the elderly is through long-term services and supports, such as funding for home health aides and nursing homes. These services can be prohibitively expensive for many, and Medicaid provides much needed coverage for the most vulnerable elderly populations.

Medicaid Enrollment 1966-2016



Source: Enrollment figures from MACPAC.

Medicaid State-by-State Facts

State	Enrollment (thousands)		Spending		Most Medicaid Enrollees Work. % of Adult Enrollees Who Are...		
	Total Medicaid/CHIP (Dec 2017)	Medicaid Expansion Newly Eligible (Dec 2016)	Federal Spending (millions of \$, 2016)	In 2018, for every \$ a state spends, the federal govt provides...	Working	Ill or Disabled, Taking Care of Home/Family, or Going to School	Either
US	74,433	11,997	362,652	1.00	60%	32%	93%
AL	890	N/A	3,964	2.50	43%	44%	88%
AK	200	27	1,246	1.00	57%	34%	91%
AZ	1,716	110	8,553	2.32	62%	31%	93%
AR	902	316	4,919	2.43	57%	37%	94%
CA	12,096	3,752	56,501	1.00	62%	31%	94%
CO	1,358	451	5,121	1.00	70%	25%	95%
CT	837	210	4,613	1.00	70%	26%	96%
DE	248	11	1,259	1.30	60%	30%	90%
DC	264	78	2,173	2.33	58%	31%	88%
FL	4,298	N/A	13,649	1.62	61%	31%	92%
GA	1,769	N/A	6,949	2.17	58%	36%	94%
HI	347	21	1,497	1.21	51%	37%	87%
ID	296	N/A	1,276	2.47	59%	31%	90%
IL	3,043	634	12,063	1.03	64%	27%	91%
IN	1,466	279	7,800	1.91	58%	32%	91%
IA	659	138	3,084	1.41	72%	23%	95%
KS	389	N/A	1,942	1.21	69%	24%	93%
KY	1,273	466	7,783	2.47	62%	35%	96%
LA	1,456	377	5,627	1.75	52%	38%	90%
ME	261	N/A	1,668	1.80	64%	34%	97%
MD	1,305	291	6,622	1.00	66%	25%	91%
MA	1,669	N/A	9,731	1.00	67%	24%	91%
MI	2,339	607	12,738	1.84	60%	33%	93%
MN	1,060	186	6,660	1.00	66%	23%	89%
MS	664	N/A	4,128	3.11	47%	46%	92%
MO	958	N/A	6,474	1.83	60%	37%	97%
MT	271	68	972	1.89	67%	29%	96%
NE	242	N/A	1,094	1.11	59%	30%	89%
NV	638	208	2,683	1.92	65%	27%	92%
NH	190	56	1,266	1.00	65%	26%	91%
NJ	1,745	547	9,182	1.00	53%	38%	91%
NM	744	260	4,370	2.59	60%	32%	92%
NY	6,472	278	34,589	1.00	57%	33%	91%
NC	2,043	N/A	8,529	2.09	57%	38%	96%
ND	94	20	836	1.00	49%	38%	86%
OH	2,846	634	15,506	1.69	61%	37%	97%
OK	780	N/A	2,926	1.41	51%	40%	91%
OR	965	388	6,686	1.75	69%	23%	93%
PA	2,970	734	17,036	1.08	64%	29%	92%
RI	313	66	1,534	1.06	68%	22%	90%
SC	1,009	N/A	4,453	2.52	51%	46%	98%
SD	118	N/A	489	1.24	55%	37%	92%
TN	1,540	N/A	6,524	1.93	57%	37%	93%
TX	4,793	N/A	23,696	1.32	49%	42%	91%
UT	300	N/A	1,574	2.36	63%	31%	94%
VT	163	N/A	1,073	1.15	69%	28%	97%
VA	1,015	N/A	4,553	1.00	48%	45%	92%
WA	1,775	605	7,062	1.00	62%	27%	89%
WV	550	181	2,946	2.74	53%	40%	93%
WI	1,034	N/A	4,694	1.43	62%	34%	96%
WY	60	N/A	337	1.00	62%	35%	97%

Source: JEC Democratic Staff analysis based on data from the Center on Medicare and Medicaid Services, MACPAC, Kaiser Family Foundation, and 2017 CPS ASEC. Adult enrollees refers to nonelderly, non-SSI adult enrollees. Federal spending includes federal share of administrative expenses.

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- ¹ <https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/medicaid-actuarial-report-2016.pdf>
- ² <https://ccf.georgetown.edu/2016/12/06/medicaid-coverage-improves-financial-security/>
- ³ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4195077/>
- ⁴ <https://www.kff.org/other/state-indicator/nonelderly-0-64/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>
- ⁵ <http://www.nber.org/oregon/3.results.html>
- ⁶ <https://www.kff.org/medicaid/issue-brief/health-care-spending-among-low-income-households-with-and-without-medicaid/>
- ⁷ JEC Democratic Staff calculations based on <https://www.kff.org/medicaid/issue-brief/health-care-spending-among-low-income-households-with-and-without-medicaid>
- ⁸ <http://www.nber.org/papers/w22170>; see also <http://libertystreeteconomics.newyorkfed.org/2016/06/is-health-insurance-good-for-your-financial-health.html>
- ⁹ <http://www.nber.org/papers/w24002>
- ¹⁰ <https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-september-2017/>; <http://www.nejm.org/doi/full/10.1056/NEJMsa1212321>
- ¹¹ <https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/>, <https://www.kff.org/medicaid/fact-sheet/medicaids-role-in-meeting-seniors-long-term-services-and-supports-needs/>
- ¹² http://www.thescanfoundation.org/sites/thescanfoundation.org/files/rti_medicaid-spend-down_3-20-13_1.pdf
- ¹³ <https://www.manatt.com/Insights/White-Papers/2017/Medicaids-Role-in-Public-Emergencies-and-Health-C>
- ¹⁴ JEC Democratic Staff calculations based on data from the Census bureau. <https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-people.html>. Note: In 1959, the Nonelderly poverty rate was 21 percent. By 1966, it was 13 percent, and in 1973 it was 10 percent.
- ¹⁵ https://dash.harvard.edu/bitstream/handle/1/14008375/Sommers_PovertyReducing.pdf?sequence=1
- ¹⁶ ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2015_SHS_Table_P-11.pdf
- ¹⁷ <https://www.kff.org/medicaid/issue-brief/medicaid-and-american-indians-and-alaska-natives/>
- ¹⁸ JEC Democratic Staff calculations based on data from the 2011 Current Population Survey and https://dash.harvard.edu/bitstream/handle/1/14008375/Sommers_PovertyReducing.pdf?sequence=1.
- ¹⁹ <http://www.policyarchive.org/handle/10207/6328>
- ²⁰ <http://www.nber.org/papers/w20835.pdf>
- ²¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4765984/>
- ²² <https://www.federalreserve.gov/econres/feds/files/2017061pap.pdf>; <https://fred.stlouisfed.org/series/CPGDPAI>
- ²³ <https://www.thirdway.org/one-pager/american-health-care-act-devastating-for-rural-america>; <https://www.cbpp.org/research/health/house-passed-bill-would-devastate-health-care-in-rural-america>
- ²⁴ <https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/>
- ²⁵ <http://www.ivantageindex.com/wp-content/uploads/2017/03/MTopchik-Chartis-Rural-Policy-Institute-020717.pdf>; <https://www.cbpp.org/research/health/house-passed-bill-would-devastate-health-care-in-rural-america>
- ²⁶ https://www.jec.senate.gov/public/_cache/files/c875b293-aa4e-410e-84e6-485963ca5cbc/medicaid-rural-hospitals-and-seniors.pdf; JEC Democratic Staff calculations based on 2015 5-year American Community Survey.
- ²⁷ <http://www.beckershospitalreview.com/finance/the-rural-hospital-closure-crisis-15-key-findings-and-trends.html>
- ²⁸ https://www.jec.senate.gov/public/_cache/files/c875b293-aa4e-410e-84e6-485963ca5cbc/medicaid-rural-hospitals-and-seniors.pdf
- ²⁹ https://www.chartisforum.com/wp-content/uploads/2017/05/The-Rural-Relevance-Study_2017.pdf
- ³⁰ Medicaid share of MAT refers to Medicaid share of payments for Buprenorphine, a commonly used drug for the treatment of prescription opioid and heroin addiction. <https://www.kff.org/infographic/medicaids-role-in-addressing-opioid-epidemic/>

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- ³¹ <http://thehill.com/blogs/pundits-blog/healthcare/313672-keep-obamacare-to-keep-progress-on-treating-opioid-disorders>, with data from <https://www.hcp.med.harvard.edu/sites/default/files/Key%20state%20SMI-OUd%20v3corrected.pdf>; <https://www.hcp.med.harvard.edu/sites/default/files/Interpretation%20of%20Tables%20SMI-SUD%20162016%20v2.pdf>; <https://aspe.hhs.gov/system/files/pdf/255456/ACAOpoid.pdf>
- ³² <https://www.thenationalcouncil.org/wp-content/uploads/2017/04/Medicaid-Expansion-Behavioral-Health-UPDATED-5-1-17.pdf>
- ³³ <https://www.brookings.edu/bpea-articles/where-have-all-the-workers-gone-an-inquiry-into-the-decline-of-the-u-s-labor-force-participation-rate/>
- ³⁴ <https://www.whitehouse.gov/wp-content/uploads/2018/02/msar-fy2019.pdf>, pp 117
- ³⁵ <http://avalere.com/expertise/life-sciences/insights/graham-cassidy-heller-johnson-bill-would-reduce-federal-funding-to-sta>
- ³⁶ <https://www.cbpp.org/research/health/medicaid-per-capita-cap-shifts-costs-to-states>; <https://www.kff.org/medicare/issue-brief/what-could-a-medicaid-per-capita-cap-mean-for-low-income-people-on-medicare/>
- ³⁷ <https://www.macpac.gov/subtopic/medicaids-share-of-state-budgets/>
- ³⁸ <https://www.cbpp.org/research/health/health-proposals-in-presidents-budget-would-reduce-health-insurance-coverage-and>
- ³⁹ <https://www.americanprogress.org/issues/poverty/reports/2014/09/10/96754/asset-limits-are-a-barrier-to-economic-security-and-mobility/>
- ⁴⁰ <https://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows#finding1>
- ⁴¹ <https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/>
- ⁴² <https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/>
- ⁴³ <http://healthaffairs.org/blog/2017/03/06/myths-about-the-medicaid-expansion-and-the-able-bodied/>.
- ⁴⁴ <https://www.healthaffairs.org/doi/10.1377/hblog20170306.059021/full/>
- ⁴⁵ <https://khn.org/morning-breakout/what-might-be-next-after-medicaid-work-mandates-lifetime-limits-on-adults-access-to-coverage/>
- ⁴⁶ <https://ccf.georgetown.edu/2018/03/08/research-update-medicaid-pulls-americans-out-of-poverty-updated-edition/>
- ⁴⁷ <https://www.kff.org/medicaid/state-indicator/federalstate-share-of-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
- ⁴⁸ The ACA specified 133, but allowed for a 5 percent income disregard, making the effective rate 138.
- ⁴⁹ <https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
- ⁵⁰ https://medicaid.alabama.gov/documents/2.0_Newsroom/2.1_About_Medicaid/2.1_Medicaid_Primer_10-12-12.pdf, <https://www.gao.gov/assets/220/211630.pdf>
- ⁵¹ <http://files.kff.org/attachment/report-medicaid-at-50>
- ⁵² <http://econofact.org/filling-in-the-gap-of-childrens-health-insurance-coverage-medicaid-and-chip>
- ⁵³ Some states opted to keep their policy of covering the elderly and individuals with disabilities using their state's eligibility standard in effect in 1972
- ⁵⁴ http://www.annualreviews.org/doi/full/10.1146/annurev.publhealth.27.021405.102145?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Aacrossref.org&rfr_dat=cr_pub%3Dpubmed&
- ⁵⁵ <http://files.kff.org/attachment/report-medicaid-at-50>