

University of Nevada, Reno

**Evolving Approaches to Healthcare Reform under the Trump Administration**

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of the requirements for the degree of

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by

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## **Abstract**

Several provisions of the Affordable Care Act (ACA) have been removed under the Trump Administration, which has negatively impacted access to healthcare for low-income populations. The Medicaid expansion outlined by the ACA proves to extend care to populations under the poverty line, and the primary barriers to expanding coverage stem from political disagreements at the state and national level rather than economic concerns. This thesis will analyze the primary issues preventing further Medicaid expansion past the levels outlined in the ACA both nationwide and in the state of Nevada, as well as illustrate the detrimental effects of restricting coverage for low-income populations. The information will ultimately be synthesized into a policy proposal of a Medicaid Buy-In option that will expand coverage without greatly increasing costs to the state.

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## Introduction

President Trump, in his 2016 presidential campaign, assured voters that he would repeal the Affordable Care Act (ACA) due to conservative voters' dissatisfaction with the new ACA policies. President Trump and Republican congressmen, however, were blocked from repealing the ACA by public opposition because Trump failed to provide an adequate healthcare policy replacement (Jost, 2017). While Trump has failed to completely repeal the ACA, the Trump administration has succeeded in removing several ACA policies intended to generate revenue and maintain coverage to marginalized populations. These marginalized populations include racial minorities as well as low-income groups. In order to prevent low-income groups from being penalized with an additional tax for not purchasing health insurance under the ACA, the Trump Administration removed the individual mandate tax (Collica-Cox, 2015). While this revision will spare low-income groups from paying a penalty for not having health insurance, the ultimate effect of the individual mandate repeal will likely be insurance premium spikes (Steinbrook, 2018). President Trump's efforts to repeal sections of the ACA and its revenue generation system have already restricted Medicaid coverage to several low-income populations, who are now unable to afford access to adequate medical care due to the rise of insurance premiums (Grogan, 2017; Himmelstein, 2017). The introduction of replacement healthcare plans, such as the American Healthcare Act, threaten to restrict Medicaid coverage even further. Benefits offered to low-income populations, such as waivers for Medicaid coverage provided to childless adults who were previously unable to access the same benefits as those in similar financial situations

until the ACA are now in jeopardy (Musumeci, Hinton, Antonisee, Hall, & Rudowitz, 2018).

The ACA in its current amended form, differs from President Trump's American Healthcare Act in terms of providing adequate medical care to low-income populations. I compared the policy differences with empirical data collected after the presidential administration change in 2017. Using existing research coupled with supplemental interviews, I determined the effects of revising the ACA with respect to rising insurance premium costs and applicability of Medicaid coverage to marginalized populations. In order to make use of existing data, I compared the Medicaid eligibility criteria between Nevada and New Mexico, drawing from the research regarding the forms of a Medicaid Buy-In to expand coverage to low-income populations. This research ultimately culminated in the creation of a policy proposal that addresses specific sections of state-based Medicaid coverage that require revision or investigation while also proposing the most politically viable means of maintaining the ACA and national expansion of Medicaid.

My thesis also analyzes previous and contemporary healthcare policies in Nevada as they apply to access to healthcare for low-income populations. Through interviews with Nevada State legislators, with advisory agencies for Nevada State legislators, and with national organizations such as the Kaiser Family Foundation, I have assessed which policy changes are infringing upon Americans' abilities to affordably seek medical care. Ultimately, my thesis synthesizes the research existing on the ACA's current status as well as a specific policy solution that will elucidate the out-of-pocket costs for low-income groups as a result of these healthcare plan revisions. By analyzing the economic

impact on these populations, I have proposed policy changes that will alleviate the economic burdens unfairly placed on indigent groups.

### **Methodology**

This study aims to review existing programs for healthcare in the US, looking at Nevada healthcare policies as a case study. Ultimately this information will be synthesized in a policy proposal for Nevada as well as the national healthcare system.

### **Literature Search and Data Compilation**

This review draws on a variety of sources. Following a comprehensive discussion of Medicaid, I addressed the existing international policy regarding the right to healthcare, which factors into the proposed 2019 revisions to the Affordable Care Act. I discuss the revisions to the ACA, providing a timeline of its creation and its implementation at the state and federal level, following Supreme Court rulings. In this timeline, I reference specific implementations of health insurance exchanges and health insurance waivers for childless adults. Finally, I discussed solutions to the current ACA revision issue, focusing on economic and political feasibility while evaluating existing proposals, such as expanding Medicaid in conjunction with private health insurance in health insurance exchanges. In order to adequately address the policy proposal issue, I incorporate a discussion regarding contemporary political party politics and the feasibility of policy revisions under current political conditions.

### **Nevada Legislature and National Organization Interviews**

My interviews are intended to provide primary-source information that supplements my review of the existing literature. I conducted 5 interviews with members of the state legislature and members of national organizations, such as the Kaiser Family

Foundation, to incorporate the perspective of research organizations operating at a federal level. By interviewing experts at the Kaiser Family Foundation and Silver State Exchange, I accessed information not yet published in research journals, and I evaluated the likelihood of different healthcare acts passing in Congress. I also interview members of the Nevada State Legislature Committees on Health and Human Services to determine the outlook for state healthcare policy. My discussions with representatives to the Nevada Assembly yielded important contextual information regarding previous attempts to expand Medicaid through which I analyzed the 2017 Nevadan legislative session's Assembly Bill 374 on adjusting Medicaid.

The studies published in *Health Affairs* and the *American Journal of Health Economics* are broad in scope, with the primary focus being on national implementation and overcoming barriers imposed by the current political alignment. My thesis benefited from incorporating the perspectives of state employees and legislators, as states currently retain the right to opt out of the Affordable Care Act's Medicaid expansion. Policy proposals for expanding Medicaid will ultimately face barriers at the state and federal levels that are often omitted from academic writing. In order to ascertain the burden placed on states in seeking the ACA's Medicaid expansion or further Medicaid expansion through a Buy-In option, I discussed the process with members of the Committees on Health and Human Services. These interviews were synthesized into policies capable of alleviating these economic burdens. In the process of performing these interviews, I attained the necessary Institutional Review Board (IRB) approval to conduct minimal-to-no-risk interviews. By informing my participants of their involvement in my thesis and the possibility of using our recorded discussion in my thesis, I was determined to be

qualified for exempt review and did not need to further pursue IRB approval. In the process of completing my thesis, I completed the Training for Human Research Oversight Responsibilities course offered by the University of Nevada, Reno (UNR) to ensure that my interactions with my interviewees reflected the research standards set by the UNR IRB.

My primary challenge in supplementing my thesis with Nevada-based interviews was maintaining a national perspective and not limiting my project to a state-based case study. While my thesis incorporates informative, in-depth interviews with elected officials serving in the 2019 Nevada legislature, my discussion of national policy changes with research organizations allows my thesis to maintain a national context. While the primary policy proposal developed from my interviews applies to the state of Nevada, the investigation and research incorporated into the policy proposal are equally applicable to other states seeking a Medicaid Buy-In expansion of healthcare coverage. In order to establish a national perspective, I conducted interviews with prominent national organizations, including the Kaiser Family Foundation, and professors at UNR specializing in health policy research at the national level. These interviews contextualized the current national party situation and elucidated policy solutions currently being considered in Congress.

In regards to the interviews, notable limitations must be addressed in order to contextualize this thesis. My primary interview candidate, the former chair of Health and Human Services, Assemblyman Sprinkle resigned during the course of my research and was therefore unavailable to be incorporated into my thesis. The discussions regarding Assemblyman Sprinkle's sponsored AB 374 from the 2017 legislative session come from

interviews with other assemblymen serving on the Committee on Health and Human Services. The quantity of interviews was also limited due to the limited time available to state representatives for in-depth interviews. While I planned to incorporate the perspectives of Assembly Ways and Means as well as the Senate Health and Human Services, the schedules of the representatives and the limited timeframe for the completion of my thesis reduced the quantity of interviews that I was able to conduct. Furthermore, my incorporation of interviews with national organizations was restricted by my limited timeframe and the lack of time available to the relevant policy analysts at organizations such as the Urban Institute. While the quantity of my interviews was restricted, the information that was provided by my participants was sufficient to inform my thesis.

## **Chronology of the Affordable Care Act**

In order to address the issues associated with the Affordable Care Act (ACA), I will account for the most significant events that have affected the ACA's implementation. This chronology will cover the time period from the creation of the ACA in the House of Representatives to the 2018 Congressional midterm elections (eHealth Insurance, 2018).

### **Creation of the ACA**

The ACA first originated in the House of Representatives when Speaker of the House Nancy Pelosi presented the bill, H.R. 3962, in July of 2009. The bill passed in the House with 219 Democrat votes and one Republican vote in favor of the bill, and 39 Democrat and 176 Republican votes against the bill. By December of 2009, the Senate created its own version of the House bill, and the Senate Democrats used the process of budget reconciliation in order to circumvent the missing 60<sup>th</sup> vote to pass the ACA. In instances where bills have a "budgetary concern," budget reconciliation priority may apply. Only a simple majority is needed and the bill is unable to be filibustered. The senate version of the bill was passed in the House, 219 to 212, and in March of 2010, President Obama signed the bill to enact the ACA.

### **90-Day Changes of the ACA**

Within the first 90 days, the ACA mandated several changes to the existing healthcare structure. First, by June 23, 2010, the ACA provided small business tax credits for up to 35% of insurance premiums to alleviate the burden of providing health benefits to employees. Additionally, citizens who were previously denied insurance or could not qualify for insurance would have access to "federal high-risk pools" in order to provide subsidized, but not free, insurance. Finally, the June 23, 2010 provisions also included

specific policies for reimbursing employment-based health insurance coverage for early retirees. By July 1, 2010, the Pre-Existing Condition Insurance Plan (PCIP) came into effect in order to provide coverage for individuals denied health insurance by private companies due to pre-existing conditions. Unfortunately, the PCIP program's costs were double the original government estimates (Roy, 2012).

### **180-Day Changes of the ACA**

The initial changes presented by the ACA were followed by 180-Day provisions that expanded the original 90-Day policies. By September 23, 2010, the ACA banned pre-existing condition coverage exclusions for children. Additionally, seniors were provided a \$250 rebate to reduce the coverage gap in Medicare Part D for prescription drugs. In an effort to increase accessibility and clarity, the government health insurance consumer information website was created for citizens to compare available insurance plans.

### **2011-2014 Provisions of the ACA**

The original language of the ACA included strict, aggressive requirements to combat health inequity by 2011. Patients were intended to receive protections with their new healthcare plans that would enable them to choose their primary care provider, stopping insurers from demanding prior authorization before admittance to emergency care or for a woman to see an obstetrician. The original language of the ACA also prohibited rescission of healthcare plans except in cases of fraud or misrepresentation. Insurance companies were also required to establish an appeals process for consumers to voice their concerns.

In addition to expanding the options for low-income populations in 2011, the ACA restructured how insurance companies were able to distribute payments to their consumers. Under the ACA, insurance providers were no longer allowed to cap annual or lifetime payments at a certain amount. Consumers were intended to be able to receive as much monetary aid as necessary, regardless of whether the aid amount exceeded annual projections. The coverage plans themselves were also modified as young adults had their dependent-coverage extended and individuals seeking insurance for preventative care were mandated to receive partial coverage for their preventative care visits.

In 2014, a new wave of requirements was mandated by the ACA. The individual mandate, or the requirement for individuals to purchase healthcare or pay a penalty fee, was implemented at this time. Health insurance exchanges opened in 2014, and individuals buying their own health insurance were provided with monthly subsidies if their annual income was lower than 400% of the poverty level (\$43,320 in 2009). By 2014, the High-Risk Insurance Pools program expired, and the previous Pre-Existing Condition Insurance Plans (PCIPs) were set to be replaced in 2014 after all of the reforms were in place. Finally, starting in 2014, there was a requirement to purchase health insurance in order to prevent individuals from waiting until they were sick to purchase insurance, and all insurance companies were required to provide health insurance to adults between the ages of 19 and 64.

### **Additional Factors Affecting ACA Implementation**

While the original provisions of the ACA were intended for a large-scale overhaul of the United States Healthcare system, several events outside of policy development affected the implementation of the ACA in practice. In 2011, a Florida court case,

*National Federation of Independent Business v. Sebelius*, ruled that several sections of the ACA were unconstitutional, which led to a Supreme Court Case. In 2012, the US Supreme Court upheld the major provisions of the ACA mandating health insurance coverage for all and a prohibition of selectivity based on preexisting conditions. In October, 2013, Republicans, led by Senator Ted Cruz, orchestrated a government shutdown until policy could be drafted to appropriate funds for the 2014 year. Additionally, the Healthcare.gov website was plagued by constant technical difficulties, creating dissent among the House of Representative Democrats and ultimately leading to the Healthcare.gov website being closed for several weeks. In March of 2014, the two-year grace period provided to individuals enrolled in non-grandfathered health insurance plans was extended and by May of 2014, 8 million people enrolled during the Open Enrollment Period for a new health insurance plan.

On March 4, 2015, the *King v. Burwell* federal court case initiated further discussion regarding the legality of the ACA and whether the federal government has the right to distribute funds through a state-run exchange system. In a 6-3 vote, the Supreme Court upheld the federal government's ability to distribute funds through the Healthcare.gov website if the state did not already have its own exchange set up. Additionally, U.S. District Judge Rosemary Collyer argued that the subsidies provided under the ACA require approval from Congress because the funds for the subsidies were not permanent.

The 2016 election dramatically shifted the outlook for the ACA, as President Trump campaigned on repealing the ACA. However, the lack of a comprehensive replacement policy and the work of the Democrat legislators stalled the wholesale repeal

of the ACA. Instead, the Republicans encouraged an implosion of the ACA by restricting its funding. In October of 2017, the Trump administration announced that the Cost Sharing Reductions (CSR) aimed at reducing individuals' deductibles would no longer be funded by the federal government. While citizens would still have access to reduced price healthcare plans, this elimination of CSRs increased the economic burden on low-income populations. Furthermore, the November Open-Enrollment Period for 2017 was reduced to 6 weeks from the previous 3-month period of recent years. In December of 2017, the individual mandate tax penalty was repealed, cutting the funding for the ACA even further. Following Trump's election, Idaho Governor C. L. Otter issued an executive order to allow insurance companies to provide less comprehensive plans in order to avoid people overpaying for plans that have unnecessary, expensive benefits.

The most recent changes to the ACA's implementation come in the form of work requirement waivers issued by the current Administrator for Medicare and Medicaid Services, Seema Verma. The work requirements provide another opportunity for the Trump Administration to restrict the application of the ACA. Considering that the work requirement waivers have been administered through the Executive branch, this change circumvented the process of Democrats using the filibuster method to stall legislation. Aside from executive-branch methods, another federal court decision in *Texas v. Azar* threatens to cripple the ACA by calling for the complete repeal of the ACA. However, considering Chief Justice Roberts' tendency to defer overly political decisions to Congress, it is unlikely that the ACA will be affected by this case.

### **Political Climate Effect on Healthcare Revisions**

Under President Trump's administration, Republicans have supported block-grant methods of allocating federal funds for Medicaid in addition to supporting alternative healthcare plans such as the American Healthcare Act. However, the 2018 midterm elections presented a substantial shift in Congressional power, as Democrats succeeded in winning 40 additional seats in the House of Representatives, securing the majority. This change in the national political climate has increased legislative gridlock and will likely prevent the wholesale repeal of the Affordable Care Act (Perez, 2019). Upon the restoration of the Democratic majority in the House, Speaker Pelosi stated that the House of Representatives would be focusing on "restoring checks and balances" on the Trump administration in terms of President Trump's plans for healthcare (Perez, 2019). In addition to a surging Democratic presence in the House of Representatives, the leadership of multiple states which have not adopted Medicaid expansion has shifted to Democratic, indicating an increased possibility of Medicaid expansion at the state level (Wilensky, 2019).

In terms of access to medical care for low-income populations, the focus has shifted from protecting ACA provisions to blocking the Trump administration's new work requirements for Medicaid provisions. The work requirement provision is still nascent, but the additional burden on individuals seeking Medicaid has already generated controversy with multiple courts cases being opened to rule on the provision's legality (Romoser, 2019). In addition to investigating and blocking the implementation of work requirements for Medicaid coverage, the Democratic House of Representatives is also focusing on addressing the current opioid epidemic. While Republican congressmen are

focusing on maintaining the work requirements and encouraging states to adopt them, Republicans in both the Senate and the House are working in a bipartisan effort to address the opioid epidemic and its disproportionate effect on low-income populations (Romoser, 2019).

The 2018 shift in the House of Representatives makes dramatic healthcare changes infeasible. With the Trump administration and a Republican Senate, improved Medicaid expansion is unlikely because it runs contrary to the Republican goals of decoupling the federal government and healthcare. However, the Democrat-controlled House will unwaveringly reject any legislation regarding the repeal of the ACA, the adoption of the AHA, or any changes regarding block-grants for states using Medicaid. While the current political climate may continue to protect the currently modified ACA, the discussion regarding the effects of the complete repeal of the ACA and the implementation of the AHA remain pertinent. First, the upcoming 2020 elections may witness the reelection of President Trump and a surge of Republican legislators on President Trump's coattails. If the Republicans control the House of Representatives again while President Trump continues in his second term, this will make healthcare revisions highly likely. In addition to the possibility of a Republican resurgence, the ACA's legality is being investigated under the Trump administration through the judiciary system. Judge Reed O'Connor determined that the entirety of the ACA is unconstitutional and worthy of repeal (Romoser, 2019). If the Trump administration is able to circumvent the legislative branch entirely and repeal the ACA based on its unconstitutionality at the Supreme Court level, the issues of the Republicans' American

Healthcare Act implementation and a dramatic change for low-income populations will be at the center of political discussion.

### **Analysis of Trump Administration's Effect on Healthcare Policy**

Access to medical care under the Affordable Care Act (ACA) has been a thoroughly researched topic since its enactment in 2010, but only a limited amount of research exists regarding limited access to medical care in the wake of the Trump Administration's health policy revisions. According to Jost (2017), the Trump Administration's proposed revisions to the ACA are occurring in a piecemeal fashion. Originally, Trump and Republican leaders agreed to repeal the entire ACA, but due to the intense public backlash, the Trump Administration changed their tactics to a "repeal, replace, and repair" model. The repeal, replace, and repair method aims to avoid severe backlash from communities covered by the Obama Administration's healthcare policies who would face poor or absent coverage if the ACA was immediately repealed with no alternative. The impacts of President Trump's healthcare reforms remain difficult to quantify due to the lack of concrete policy. Jost (2017) confirms that the Trump Administration has already limited advertising funding for the ACA and witnessed a reduction of 400,000 Americans enrolled through the ACA's Healthcare.gov health insurance exchange website. Steinbrook (2018) argues that the recent repeal of the individual mandate, the requirement for each person to purchase insurance or pay a penalization fee, may have significant impacts on the contemporary insurance market. The loss of revenue from removing the individual mandate will likely accelerate insurance premiums and reduce the selection of comprehensive healthcare plans from insurance providers. Dyer (2018) confirms these reports and adds that the Trump

Administration has allowed states to deny Medicaid coverage to unemployed individuals who are not actively seeking employment. The Trump Administration has indicated that these working requirements policies for unemployed individuals may be amended to also raise the net insurance premiums on childless couples with incomes over the federal poverty line of \$15,000 per year.

While the currently enacted reforms to the ACA have already impacted low-income populations and reduced Medicaid enrollment, the majority of the ACA's policies remain intact at the state level. Himmelstein and Woolhandler (2017) argue that the Trump Administration's lack of enacted policy is due to the Democratic Party's efforts to block the ACA revision process and prevent policy proposals such as the 2017 American Healthcare Act and the Better Way Plan proposed by Paul Ryan. Furthermore, Trump's polarizing healthcare proposals have the potential to generate newfound support for progressive policies, such as sliding-scale income taxes to fund Medicaid expansions.

The most appropriate approach for understanding the tumultuousness of the contemporary healthcare situation is to evaluate the possible effects of repealing sections of the ACA, and to understand how the Republican party's proposed block-grant system would strip marginalized populations of adequate coverage. Grogan (2017) elucidates the key differences between the Trump Administration's proposed healthcare and the ACA with regards to health equity. Each one of the ten titles of the ACA includes specific language focused on achieving health equity (Patient Protection and Affordable Care Act, 2010). Specifically, section 1557 of Title I of the ACA prohibits intentional discrimination as well as unintended discrimination on the basis of gender, disability, age, race or ethnicity. Section 2951 of Title II of the ACA addresses improvements to the

early childhood home visiting programs for at-risk communities, with requirements placed on the state to address the needs of at-risk communities with a mandatory “needs assessment.” The proposed American Healthcare Act, or Trumpcare, does not include language dealing with health equity and proposes to move healthcare coverage to the “truly deserving” populations covered before the ACA (Grogan, 2017). In his study of how Trumpcare would affect coverage of United States citizens, McCarthy (2017) found that low-income groups would be hit the hardest, and that the majority of healthy youth would be forced to purchase “bare bones” insurance plans with extremely limited coverage. McCarthy (2017) reports that an individual with a yearly salary of \$26,500 would pay \$1,700 for coverage under the ACA, but would pay \$13,500 under Trumpcare due to increased premiums and reduced government subsidies. Grogan (2017) and McCarthy’s (2017) findings regarding the limited scope of the American Healthcare Act are supplemented by the writings of Allen (2017), who provides a physician’s perspective on the revisions to the ACA.

Changing the Medicaid subsidies to a tax deduction rather than a tax credit indirectly favors higher-income patients, and this change will result in up to an additional 15 million uninsured Americans. In addition to changing tax credits to tax deductions, the American Healthcare Act would substantially reduce funding to Academic Medical Centers (AMCs) and safety-net hospitals, which provide care to a financially challenged client base. Furlow (2017) supports these findings by addressing how reduced funding to safety-net providers and hospitals will likely result in a rise in untreated chronic illnesses. Furlow argues that cancer cases will be especially difficult for marginalized populations to pay for under Trumpcare, as the budget cuts to AMCs as well as the requirement to

pay out-of-pocket will disproportionately affect minorities and low-income groups. The proposed cuts to safety-net hospitals have potentially lethal effects on low-income individuals, especially Hispanic populations (Angel & Berlinger, 2018). Low-income Hispanic families of Mexican descent are more frequently dependent on social programs and have substantially higher morbidity rates that require constant care for chronic diseases (Angel & Berlinger, 2018). The proposed revisions to the ACA under Trumpcare would incentivize turning away patients who are unable to provide adequate payment for care of chronic, preexisting conditions.

Wen's (2017) description of the United States' opioid epidemic, associated with Opioid Use Disorder (OUD), provides a useful case study of the detrimental effects of Trumpcare. Considering that 2.6 million Americans suffer from OUD and over 33,000 Americans die each year due to overdosing on opioids, treatment programs have become increasingly important (Wen, 2017). The Medicaid expansion under the ACA has increased the amount of treatment opportunities for OUD, which remains an epidemic in the United States. Wen (2017) argues that the proposed Medicaid cuts under Trumpcare will exacerbate the OUD issue as treatment programs will lose Medicaid patients. Considering the propensity for children of untreated OUD parents to abuse opioids themselves, Trumpcare has the potential to worsen the vicious cycle of OUD (Wen, 2017).

### **Evaluating the Cost of Medicaid Expansion**

The primary Republican opposition to Medicaid expansion stems from the conservative focus on reducing government spending. Ayanian (2017), however, argues that the Medicaid expansion in Michigan provides evidence of the ACA's direct fiscal

incentives to states as well as long-term boons through increased economic activity. The Medicaid expansion is primarily financed by the federal government, which receives funding from progressive income taxes. Since the bulk of the Medicaid expansion (100% of the costs at the start and then 90% by 2020) is covered by the federal government, the states are incentivized to participate in the Medicaid expansion. While the states involved in the Medicaid expansion are forced to adjust their budgets to pay for greater coverage, the overall increase to medical care provides for increased economic activity and greater revenue for the state. This effect of increased economic activity especially applies to low-income families, who are able to divert their spending on medical insurance to consumer goods and household expenses that generate state revenue through sales tax. In addition, insurance providers are given monetary incentives to participate (Ayanian, 2017).

Ayanian's (2017) economic findings are supported by the Urban Institute's report on the funding logistics for the ACA (Dorn, 2014). The Urban Institute's report finds that the original ACA intended for sliding-scale taxes to be applied based on income, which would offset costs for low-income groups. The taxes collected from the top 2% of income-earning citizens would cover 17% of the total funding required for the ACA's Medicaid expansion. With progressive tax programs and increased state revenue due to redirected economic activity, Medicaid expansion's supposed costs have been largely overstated due to political party bias.

### **Existing Proposals for Maintaining Medicaid Coverage**

In order to avoid the potential coverage restrictions of the American Healthcare Act, one may reference the proposed solutions of the Trump Administration or develop bipartisan methods to preserve the bulk of the ACA. Fuchs (2015) explains how the high

cost of American medical care and large population of uninsured individuals are difficult to rectify. The American political system entails multiple barriers to extreme change or overhauls to the healthcare industry, including party conflict that can stifle healthcare reforms. Furthermore, Fuchs (2015) explains that individuals are unlikely to favor healthcare changes that improve the overall health coverage situation if certain groups stand to lose existing benefits or coverage. Fuchs' (2015) analysis makes Sparer's (2016) proposed solution more attractive; Sparer (2016) argues that Medicaid managed exchange plans can provide more opportunities for low-income groups, avoid unnecessary changes to a preexisting healthcare structure and maintain the "private insurer market" that is extolled by Republicans opposing the ACA. Sparer (2016) calls for Medicaid to provide competitive healthcare plans when only one insurer is participating, which would increase the selection opportunities for individuals purchasing healthcare.

The current Administrator of the Centers for Medicare and Medicaid Services, Seema Verma, plans to implement a working requirement for Medicaid coverage. States implementing Verma's proposal would use health benefits as incentives to encourage citizens to work 80 hours a month or engage in volunteering (Jaffe, 2018). While this program is still under development, Verma describes this proposed solution as a ladder out of poverty, encouraging individuals to increase their current living standards and move into better-paying jobs. Verma's solution is already meeting opposition as many argue that this proposal will only increase barriers to acquiring medical care with mandatory reports and additional requirements.

## Nevada Case Study

The changes to the Affordable Care Act (ACA) under the Trump administration have caused several states to reject further Medicaid expansion. The proposal for block grants and the power of executive orders have limited the Affordable Care Act's revenue generation as Republicans plan for the ACA to implode rather than be directly replaced through legislative action. Despite the lack of support at the federal level, several states are continuing with Medicaid expansions to improve reimbursement rates and expand the original Cost Sharing Reduction payments. In the 2017 state legislative session, the Nevada State Assembly introduced AB 374, which entailed an overhaul of Nevada's Medicaid system. While the bill was vetoed by Republican Governor Sandoval on June 16, 2017, the current Democratic Governor Sisolak has stated that he would be amenable to approving an amended form of the bill if it was able to pass through both of the houses.

As originally outlined in the ACA, AB 374 would expand the Medicaid reimbursement rates to hospitals and expand the eligibility for a government subsidized plan to populations earning more than 138% of the federal poverty line. Additionally, the budget for the Medicaid coverage expansion would require greater funding from the federal government to accomplish the expansion. While the original language of the bill entailed expanding Medicaid for all individuals regardless of income level, the amended version that was passed by both houses in 2017 primarily called for the state director of Health and Human Services to create contracts with private insurers. These contracts would provide for a "Nevada Care Plan" that would provide adequate coverage for all individuals and appropriate cost sharing reductions as applicable. However, the

ambiguity of the bill led Governor Sandoval to veto the bill in its 2017 form. The process of creating a Medicaid for All system involves possible violations of federal insurance regulations, which were not addressed in the 2017 session. For the current 2019 session, the proposed Medicaid expansion was to be implemented through a state-run marketplace and insurance website that would avoid the regulations implemented at the federal health insurance marketplace.

The 2019 political landscape for the state of Nevada shifted with the replacement of the chair of Health and Human Services. AB 374, which was intended to be revised and clarified in the interim session was not reintroduced in the 2019 legislative session and Assemblyman Sprinkle, the original creator of the bill, is not expected to continue with AB 374 policy work. However, considering the need for adequate coverage for populations making more than 138% of the federal poverty level, the bill has the potential to be reintroduced into the legislature (Carrillo, 2019). During the hearings for AB 374, several representatives from the Silver State Health Insurance Exchange, the Division of Health Care Financing and Policy, and the Nevada Primary Care Association testified in support of AB 374 and further Medicaid expansion. The need to improve reimbursement rates in Nevada as well as the variety of coverage options remains exigent and in alignment with the Nevada 2019 “Blueprint,” which represents the general policy directives of the Nevada state leadership.

While AB 374 was not reintroduced in the 2019 session, Nevada legislators are still looking to enhance coverage for low-income populations by focusing on individuals suffering from the effects of drug abuse as well providing for an actuarial study regarding reimbursement rates for Medicaid. Considering the disproportionate effects of drug abuse

on minority and low-income populations, the contemporary focus in Nevada on improving the protocol and treatment process for individuals suffering from opioid addictions is of paramount importance and follows the national trend of managing the effects of the opioid epidemic. The decision to veto AB 374 instead of implementing the bill into Nevada state law was primarily due to a lack of specificity regarding reimbursement rates and cost sharing reductions associated with the Nevada State Plan. The actuarial study approved in the 2019 legislative session will allow for a funded investigation into the process of amending Medicaid reimbursement rates, which may lay the groundwork for the reintroduction of AB 374 in future legislative sessions.

### **Outlook for 2019 Congress**

The 2018 shift in the House of Representatives from a Republican to a Democratic majority has as much as guaranteed Congressional gridlock for the remainder of President Trump's presidential term (Gelman, 2019). The contentious relationship between President Trump and House Democrats indicates that a complete overhaul of the American healthcare system is infeasible and will likely result in a stalemate for all contemporary health policy. As former House Speaker John Boehner stated, "Republicans never ever one time agreed on what a healthcare proposal should look like." The upcoming election in 2020 will substantially affect the outlook for health policy, as a Democratic majority in conjunction with a new Democratic president will likely result in a bolstered Affordable Care Act or an expansion of coverage with a proposed "Medicare-for-All" system that would almost entirely abolish the private insurance market. Conversely, a Republican majority with the reelection of President Trump may result in the continued revision of the ACA and ultimately its replacement by

a plan such as the American Healthcare Act. The individual mandate is likely to be readdressed, as insurance premiums continue to rise as a result of the primary revenue generating policy being removed from the original ACA. Democrats, upon achieving a legislative majority and presidential leadership, will likely reinstitute the individual mandate or some form of revenue system to maintain expanded coverage nationally.

Unfortunately, consideration of the political reality of contemporary Congress makes all discussion of future healthcare policy speculative. The analysis of the congressional outlook for Medicaid expansions or increased revenue to support the existing framework of Medicaid coverage is entirely contingent upon the outcome of the 2020 presidential election, as cooperation between the opposing parties under the Trump administration is unlikely on an issue such as healthcare.

## Policy Proposal

The Trump administration has made its intentions clear regarding the eventual replacement of the ACA, though this legislative action is unlikely to occur before 2020 (Gelman, 2019). Upon considering the political landscape at the national level and the need to expand coverage without relying solely on federal funding, the most feasible option for Nevada would be to further explore a Medicaid Buy-In option.

AB 374, the 2017 Nevada Medicaid Buy-In proposal to expand coverage to individuals within 400% of the federal poverty line, was able to pass in both state legislative houses. The bill, however, was unable to be codified into Nevada state law due to the lack of clarity regarding the implementation of the Medicaid Buy-In with the proposed “Nevada Care Plan.” While Medicaid expansion has been proven to expand coverage and reduce the rate of uninsured, the benefits of further Medicaid expansions that extend past the Medicaid expansion outlined in the ACA cannot be accessed if a source of funding is not secured. Even with federal subsidies, the state funds required for further Medicaid expansion are difficult to acquire without raising taxes on the citizens of the state. The Trump administration along with the current head of the Center for Medicaid Services (CMS), Seema Verma, have repealed the individual mandate and approved several states’ requests for work requirements to limit the extent and application of Medicaid coverage. With this political reality in mind, a proposal for a primarily federal-funded Medicaid expansion is infeasible and would likely encounter resistance after being submitted as a state-plan amendment. Without substantial federal funding, the fiscal burden of expanding coverage would fall solely on the state budget. With Governor Sisolak’s election into office, however, the Nevada Executive has

committed to avoiding any new taxes to generate revenue. The only option available in terms of revenue generation through taxation is the extension of existing tax policies' sunset clauses, which is currently being used to generate funding for education.

Acknowledging the political climate and reality of the Nevada budget, the process of a Nevadan Medicaid Buy-In expansion must prioritize funding in order to succeed. In order to propose a policy solution to the Nevada healthcare access issue and, ultimately, a national policy proposal, I will discuss the process of the Medicaid Buy-In currently underway in New Mexico.

### **Medicaid Buy-In Forms**

A Medicaid Buy-In proposal primarily aims to extend existing Medicaid coverage metrics to cover individuals in a greater salary bracket or individuals requiring additional legal protections (i.e., individuals with intellectual disabilities, Native American groups, etc.). The process of a Medicaid Buy-In relates to any form of expanding Medicaid coverage, which means that there is no single "Medicaid Buy-In" policy being implemented at the state level. In the instance of New Mexico's ongoing Medicaid Buy-In expansion, the process of a Medicaid Buy-In has been divided into 4 options (Brooks-LaSure, Boozang, Davis, & Traube, 2018). First, the Medicaid Buy-In could be created as a Targeted Medicaid Buy-In that would offer cheaper coverage plans for individuals within or slightly above 400% of the federal poverty line. This option would rely on state funding to offset the costs of the coverage but aims to see cost savings by adding a sliding scale of coverage based on income and by recruiting healthier individuals into the risk pools. Second, the Medicaid Buy-In could take the form of a Qualified Health Plan (QHP). The Qualified Health Plan public option would entail the state offering more

subsidized plans to individuals seeking affordable care and would require the federal waivers for QHP approval as well as a 1332 waiver to create savings that would help fund the QHP creation. This option would likely encourage greater enrollment for uninsured individuals compared to a “Targeted Medicaid Buy-In,” but the federal approval process would be arduous and time-consuming considering the requirement to prove that the QHP option will save money for the federal government. Furthermore, the creation of QHP’s as an affordable option for state residents may have the effect of decreasing economic competition for the insurance market if insurance companies are not able to compete with the reduced prices of QHP’s.

The third form that a Medicaid Buy-In option may take is the creation of a “Basic Health Program” that would improve coverage for individuals with incomes that fall between 138% and 200% of the federal poverty level. Under the current form of the Affordable Care Act, states retain the right to create Basic Health Programs, or state-based plans that extend coverage to populations unable to afford care. While this option provides a great amount of flexibility for the state to control which populations would be eligible for this coverage, the burden falls upon the state to design the coverage plan and to acquire federal approval for the implementation of the BHP. The Basic Health Plan option is favorable due to the reduced financial pressure on the state and the creation of a new risk pool that would insulate the state from less healthy individuals requiring financial assistance. The funding for individuals covered in a Basic Health Program falls primarily on the federal government, which would provide for 95% of the cost of subsidies and tax credits to finance the BHP coverage plans. Considering the limited risk for the state and the majority of the financial responsibility falling on the federal

government, this option may be the most politically feasible option for the state of Nevada. While AB 374 was vetoed due to the lack of a concrete proposal in place for the implementation of a Nevada State Plan, the idea of a Nevada State Plan warrants further investigation. The creation of a Nevada State Plan aligns with the logic of a Basic Healthcare Program, which passed in both state legislative houses and would likely be implemented if federal funding was approved and the specific language of the Nevada State Plan was drafted. Another benefit of this option is the possibility of the BHP being extended to cover individuals that make more than 200% of the federal poverty line if the BHP is successful and a 1332 waiver is approved to help fund the BHP expansion.

The fourth and final way in which a Medicaid Buy-In could appear is in the form of a Medicaid Buy-In for All system, which would offer Medicaid coverage to all individuals as a low-cost option outside of the insurance market. This option would allow for individuals to apply their tax credit subsidies to the cost of the Medicaid plans and would extend coverage to the greatest number of people. While this option is considered the best method in terms of extending care to populations desiring adequate and affordable medical coverage, the risks associated with this option are substantial. This off-market option would require a 1332 waiver to prove deficit neutrality to the federal government for individuals enrolling in the new coverage option, which is unpredictable. If the state incurs a large number of less healthy enrollees who require payment and cost sharing, the federal government will only cover a certain extent of the subsidies and the rest of the costs will be the responsibility of the state. Conversely, if the new Medicaid coverage plan draws a large number of healthy enrollees, then the insurance market risk pools will be filled with a higher number of less healthy individuals and cause insurance

premiums to spike. This will encourage further enrollment into the new Medicaid coverage plan offered by the state, which will ultimately increase costs and the financial responsibility of the state. While this option of a Medicaid Buy-In For All has a greater potential to expand coverage to low-income populations than the other plans, the high risk associated with the plan means that the pricing and applicable cost sharing reductions will need to be meticulously crafted and the projections must be thoroughly vetted to avoid a sizable financial burden being placed on the state.

Considering the costs and benefits of each of the 4 Medicaid Buy-In forms in conjunction with the political reality of the Nevada State Legislature, I find the Basic Health Program option to be the most favorable and best solution for improving access to adequate medical care for low-income populations.

### **Nevada Basic Health Program Solution**

The 2017 Nevada legislative session's AB 374 represents a step in the right direction for expanding coverage to low-income groups. The Nevada State Plan should be considered as a Basic Healthcare Program, aiming to expand Medicaid coverage and cost sharing reductions to individuals whose salaries fall between 138% and 200% of the federal poverty line. Additionally, individuals who are ineligible to purchase insurance on the insurance marketplace would be eligible for the Nevadan BHP, which would substantially reduce the need for Nevada legislators to seek approval under section 1331 outlined by the Affordable Care Act as the 1332 waiver to allocate federal tax subsidies as funding for a state-offered plan is not required unless the coverage is extended past the 200% poverty line. In accordance with Nevada's contemporary state focus on not raising taxes and minimizing costs to the state, the Basic Health Program has the greatest

potential to be passed into law. The 5% cost responsibility placed on the state of Nevada may ultimately become a sizable financial burden on the state budget, but this cost may be mitigated through an extension of sunset clauses on existing taxes or redistribution of funds allocated for Nevada healthcare.

The benefits for the implementation of a Nevada Basic Health Plan are substantial. First, the flexibility of a BHP allows for the state to coordinate with the existing health insurance organizations (Health Plan of Nevada and Sierra Health and Life). The coverage plans will use the existing distribution channels and applications process, which will streamline the Basic Healthcare Program's implementation. The Basic Healthcare Program also relies on the existing ACA section 1331, which is likely to be approved through the Center for Medicaid Services as long as the requirements listed in the Basic Healthcare Program Blueprint are met. Considering the progress made by AB 374, which passed in both legislative houses, a completed Basic Healthcare Program blueprint and a projection of the reduced costs on the state would likely be received favorably at the state level. As long as the healthcare reform outlines favorable, comprehensive coverage for low-income populations and the funding is secured without further taxing the Nevadan residents, a Medicaid Buy-In proposal should be approved by the leadership and pass in both legislative houses (Carrillo, 2019). One of the issues outlined by the Targeted Medicaid Buy-In option is the size of enrollment, as Medicaid Buy-In plans often provide increased coverage for only certain groups of the population needing healthcare reform. With the creation of a Basic Healthcare Program, this issue is mitigated as the state may use the success of the BHP to justify further Medicaid expansion through a 1332 waiver by documenting deficit neutrality. The Basic

Healthcare Program allows for the state to increase coverage to multiple marginalized groups (e.g., low-income and newly immigrated) while substantially reducing the state's financial risk. The BHP will allow for the state to document the costs associated with increased Medicaid-like coverage in order to justify an expansion with the use of a 1332 waiver for federal fund allocation and the expansion of the Nevada BHP to be offered to individuals past the 200% cutoff for BHP eligibility.

The Basic Healthcare Program may represent the most politically feasible Medicaid Buy-In option to expand coverage to low-income populations, but the option's risks and drawbacks may limit the scope or lengthen the timeline of the Nevada BHP. First, the BHP creates a separate risk pool, which may detrimentally affect the individual marketplace or increase the enrollment into the BHP to the point where the state is unable to adequately fund the low-cost coverage. The shift of many enrollees into the BHP may cause the individual insurance market to raise premiums to account for the loss of enrollees in the 138%-200% federal poverty line salary bracket. Assisting individuals needing coverage below the 200% federal poverty line cutoff may place additional burdens on individuals at the cusp of the federally determined poverty level (Brooks-LaSure, Boozang, Davis, & Traube, 2018). This issue of individuals near the 200% cutoff bearing additional costs becomes even more significant when considering the "family glitch," an issue that entails individuals receiving subsidies to cover the cost of their own coverage but no financial assistance to provide coverage options for their children or spouses (Luthra, 2018). Insurance premium spikes on the individual market will likely exacerbate the problem of providing accessible healthcare coverage for low-income populations, which warrants a thoroughly vetted pricing and cost sharing reduction level

for the BHP in order to avoid destabilizing the insurance market. In addition to the risks posed by the insurance market fluctuation, the process of submitting a Basic Healthcare Program blueprint requires federal approval and an expansion of the Medicaid Buy-In structure through a 1332 waiver requires extensive documentation to prove deficit neutrality. Considering the national political alignment and the current head of CMS's support of President Trump's stance on Medicaid expansion and the Affordable Care Act, a proposal for a Basic Healthcare Program may be either rejected or the executive government may stymie any current Medicaid Buy-In expansion attempts until the Trump administration is able to further amend the ACA or implement its own replacement. Nevertheless, section 1331 BHP creation measures are often approved if the requirements outlined by the ACA are met, which serves to increase the political viability of a Nevada BHP.

While the nascent AB 374 Nevada State Plan represents a step in the right direction for increasing healthcare coverage for marginalized populations, the lack of specificity must be remedied in order to meet the requirements set by section 1331. The Nevada State Plan must be drafted in conjunction with the Silver State Exchange and through multiple meetings with representatives of both the Health Plan of Nevada and Sierra Health and Life in order to propose a comprehensive coverage option for individuals between 138% and 200% of the federal poverty line. The Nevadan BHP must cover the 10 essential health benefits outlined by the ACA, and the coverage premiums and financial burden must not exceed the levels outlined in the blueprint protocol for 1331 applicability. The Nevada State Legislature did not reintroduce AB 374 this session due to leadership changes in the State Assembly, but the need for increased healthcare

coverage remains exigent and will likely be reintroduced by the Nevadan legislative leadership in the upcoming 2021 session. In the interim, advocates for the Medicaid Buy- In option and members of the Health and Human Services legislative committees should meet with representatives from the insurance companies in order to provide more specific language in the bill and attach the appropriate fiscal notes. With the specifics of the bill determined by and the financial responsibility for the expansion primarily belonging to the federal government, Nevada has the chance to implement meaningful policy that will dramatically increase the quality and scope of healthcare coverage to low-income populations.

### **National Policy Solution**

The solution to the national coverage issue is less straightforward, as congressional gridlock is likely to limit any meaningful policy developments in the foreseeable future (Gelman, 2019). The wholesale repeal of the ACA is no longer possible with the Democratic Party regaining majority control of the House of Representatives. Considering the orientation of the Trump administration, expansion of the coverage provided by the Affordable Care Act is also improbable. The most feasible policy options available in regards to expanding national coverage include the reinstatement of the individual mandate, addressing the “family glitch,” the removal of work requirements, and the continuation of the Medicaid expansion process provided by the Affordable Care Act.

The individual mandate was a substantial source of funding for the Affordable Care Act’s subsidization of health insurance premiums, and its repeal is reducing coverage by millions of individuals (Eibner & Nowak, 2017). In order for increased

coverage for low-income individuals to expand in quality and scope, the individual mandate or an additional tax must be levied on United States citizens. Considering how additional taxation is frequently received negatively and often fails to generate support in the national legislature, the most politically feasible method is to reinstate the individual mandate and continue to provide reduced-cost health coverage to all citizens. This policy change will bolster the ACA and encourage states to expand Medicaid coverage to uninsured individuals while maintaining a revenue stream through the mandatory payment. Furthermore, the individual mandate will reduce insurance premiums by spreading the cost of medical coverage over all citizens rather than encouraging premium spikes to account for a lack of enrollment. The rise of insurance premiums causes enrollees to opt out of coverage, which only further increases the overall cost of insurance premiums. For maintaining and ultimately expanding coverage to low-income populations at the national level, the funding originally coming from the individual mandate must be restored.

In addition to restoring the individual mandate, legislators and lobbying groups at the national level must continue to address the “family glitch” of the ACA, which results in individuals being able to afford their own coverage but not coverage for their families. The solution to this issue is also contingent upon the Trump Administration either changing in 2020 or the Democrats being able to levy their majority influence to address the eligibility requirements for federal subsidies and cost-sharing reductions. The 2018 elections were substantially influenced by this “family glitch” issue, as many Democratic representatives and senators were elected due to their commitment to rectifying this issue (Luthra, 2018). Solving this issue of eligibility for federal subsidies is not without

contention, as projected costs for the expanded coverage range from \$9-10 billion (Nowak, Saltzman, & Cordova, 2015). The increase in projected costs makes this issue unlikely to be resolved under the Trump Administration, but the effects of this “family glitch” and its propensity to restrict coverage to low-income households warrants the continued pursuit of revised eligibility requirements for federal subsidies. Both the reinstatement of the individual mandate and expansion of the eligibility requirements to resolve the “family glitch” are of paramount importance to expanding coverage at a national level, but both will likely require a greater majority of Democrat representatives and senators as well as a change in the presidential administration.

Unlike the previous two policy areas requiring revision, the repeal of work requirements is significantly more feasible in the current national political landscape. Work requirements approved by Seema Verma of CMS have been documented to restrict coverage and impose a deterrent effect for low-income and marginalized populations to seek coverage. Navigating the options and coverage packages often becomes difficult for low-income individuals seeking care, especially marginalized groups such as immigrant populations. Placing additional burdens of proof on individuals seeking federal subsidies without further expansion of educational programs and outreach will further increase the uninsured population. Based on the Kaiser Foundation’s analysis of the 2016 data regarding Medicaid recipients’ job statuses, only 2 to 5 million people of the 25 million non-elderly individuals receiving Medicaid assistance would be able to work (Garfield & Rudowitz, 2018). The remaining 20-23 million individuals are either working already, on disability, serving as the caretaker for their family, or attending school and would not be able to work. The requirement to prove that Medicaid recipients are working a certain

amount of hours each week aligns with the political rhetoric of inspiring individuals to move upward out of poverty, but ultimately the burden of proof will discourage individuals from seeking coverage. This issue becomes even more problematic when considering the future costs of emergency services rendered to individuals without insurance coverage. When a greater number of patients seek emergency services or behavioral health services without insurance, the costs are the responsibility of the hospitals and, ultimately, the state (Antonisse, Garfield, Rudowitz, & Artiga, 2018). Increases in Medicaid expansion and coverage of low-income individuals has the potential to increase revenue for the state and offset costs from emergency services and care. The implementation of work requirements prevents the realization of these cost saving measures, as many recipients of Medicaid will be discouraged from continuing to apply for Medicaid subsidies and health insurance altogether.

The issues associated with the implementation of work requirements to restrict Medicaid coverage provide evidence to support the further expansion of Medicaid under the ACA. While many states took advantage of the Medicaid expansion option listed in the Affordable Care Act, 14 states have continued to refuse a further Medicaid expansion due to the additional costs of Medicaid subsidies or political orientation. A substantial barrier to expanding Medicaid through the Affordable Care Act is the political alignment of Republican vs. Democrat. The ACA, colloquially known as Obamacare, is inextricably linked to the Democratic Party and therefore generates animosity within conservative, Republican states. The Medicaid expansion described under the ACA provides Medicaid assistance and cost sharing reductions to individuals under 138% of the federal poverty line, which has been shown to improve coverage rates without negatively impacting state

spending. The cost savings experienced through reduced uncompensated care at hospitals and the expansion of the health sector as a result of the Medicaid expansion prove that the Medicaid expansion under the ACA is proven to enhance coverage without detrimentally affecting the state budget for healthcare spending (Antonisse, 2019). State expansion of Medicaid under the ACA is continuing to occur, with states like Idaho recently approving a Medicaid expansion, but the process should continue in more conservative states in order to reduce the national uninsured population. The well-documented effects of economic growth and enhanced coverage as a result of the Medicaid expansion under the ACA warrant the continuation of the expansion in the 14 states which have yet to complete the process. The process for seeking approval of a Medicaid expansion under the ACA has been streamlined so that states seeking expanded coverage are all but guaranteed to be approved for coverage as long as the conditions listed in the ACA are met. This reduces the possibility of the Trump Administration and executive agencies restricting the states from pursuing this expanded coverage option. With the process proven solvent and effective at expanding care to low-income populations, the continued expansion of Medicaid under the ACA is a politically feasible step that accomplishes the goal of improving access to healthcare.

## Conclusion

The Trump administration's commitment to reducing spending on healthcare and approving policies intended to limit the application of Medicaid make discussions regarding the expansion of coverage to low-income populations all the more important. Proposed Republican ACA replacement plans such as the American Healthcare Act are projected to thoroughly restrict coverage to low-income and minority groups if implemented. The 2018 legislative shift as a result of a secured Democratic majority in the House of Representatives has effectively postponed meaningful changes to healthcare policy at the national level. The House will block any legitimate attempt at restricting healthcare by repealing the ACA and the Trump administration as well as the Senate will stop any progress on further expanding Medicaid eligibility or reinstating the individual mandate.

The more important discussion of expanding coverage to low-income populations under the Trump administration involves changes at the state level. In a national context, the 14 states who have opted out of Medicaid expansion under the ACA should refer to the documented economic success and increased coverage of states that have expanded Medicaid under the ACA. In situations where states have a Democratic leadership and majority in the state legislature, the option of a Medicaid Buy-In through the creation of a Basic Health Program proves to be an appealing solution to combat the rising population of uninsured individuals. By using the metrics of avoiding state spending while maintaining a moderate to high potential enrollment, the creation of a Basic Health Program proves to be viable even in the political landscape of the Trump administration. The clear process for acquiring approval for a Basic Health Program allows for states to

bypass blocks to confirmation provided by executive agencies. The revision of eligibility requirements for Medicaid application to increase the scope of serviced marginalized populations proves to be the most effective method for expanding and improving healthcare. With the success of AB 374 in Nevada and the continued pursuit of a Medicaid Buy-In option in New Mexico, the outlook for expanded care at the state level looks promising. The actuarial study created by the 2019 Nevada legislature may provide more information regarding the specific rates needed in the creation of a Nevada State Plan, with which other states may be able to base their own Medicaid Buy-In expansions on. Based on the research synthesized in this thesis, Medicaid reimbursement rate revision and enhanced cooperation between private insurers and state based Medicaid Buy-In plans warrants further investigation in order to meet the demands of low-income populations seeking adequate medical care.

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