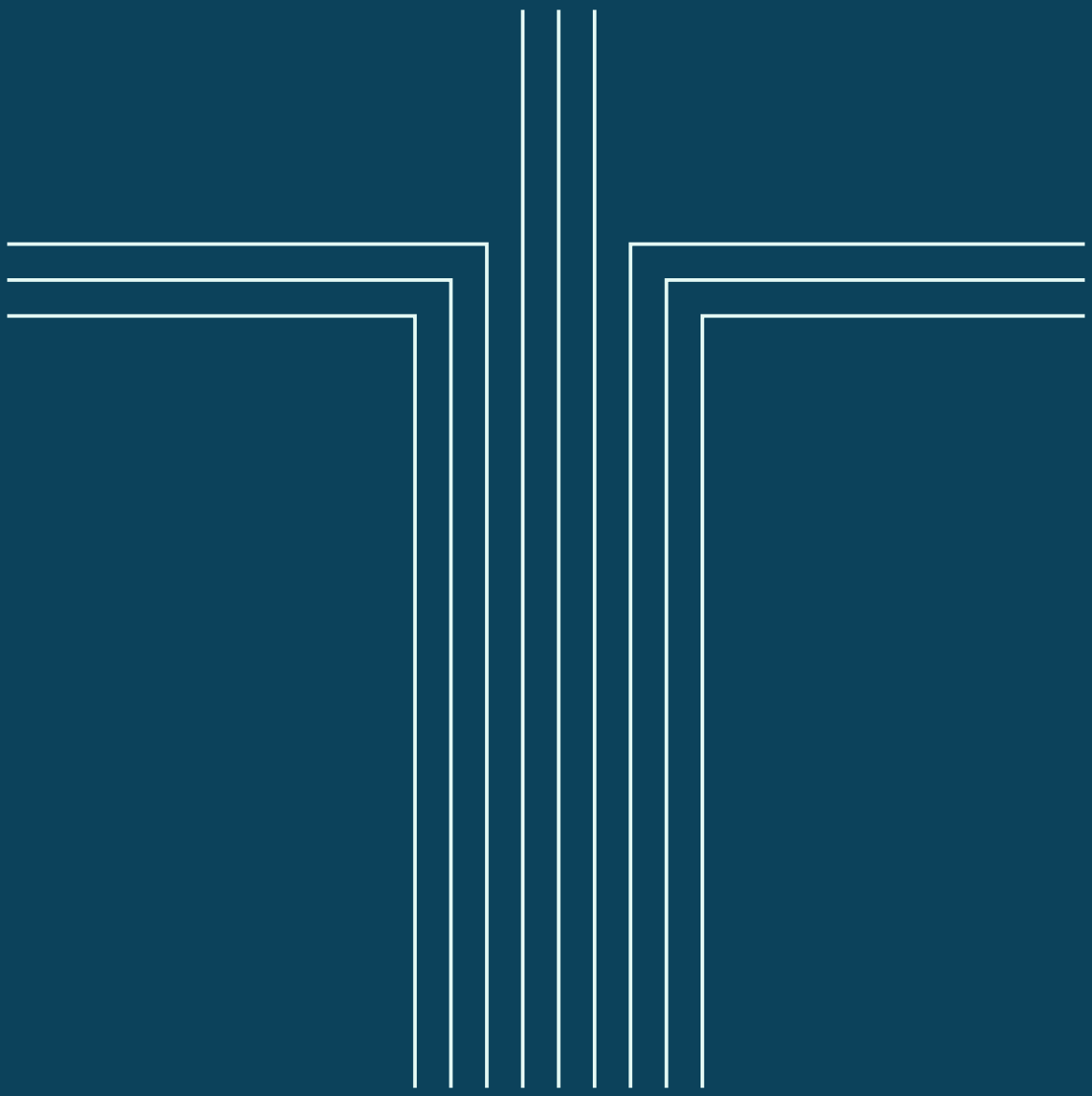
Medicaid and the Struggle for Universal Healthcare in the Trump Aftermath



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COMMONWEALTH

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Key Points

- Republicans enacted the largest cuts to Medicaid — a public source of health insurance for 1 in 5 low-income Americans — in the program's 60-year history. The legislation, combined with the expiration of Affordable Care Act tax credits, is expected to increase the ranks of the uninsured by 17 million by 2034. The massive coverage losses and economic dislocations that will stem from this historic policy change should create an important window of political opportunity for building working-class power towards the goal of universal health care.

- Over the last half-century, Medicaid has evolved from a narrow program into a cornerstone of the American health care system as both a payer for health insurance and a source of stability for regional economies. This creates unprecedented opportunities to link beneficiary organizing with broader economic coalitions including health care workers and unions towards expanding Medicaid to universal health care.

- Making the most of this opportunity requires reckoning with Medicaid's political contradictions. Despite its growth into a middle-class entitlement with broad public support, Medicaid remains

vulnerable to retrenchment due to a combination of decentralization, privatization, and means testing — program design features which raise the costs of collective action.

- → Harnessing the power of Medicaid will necessitate building linkages between workers and beneficiaries, forging cross-program solidarity, and confronting the abuses wrought by privatization.
- → In addition to national efforts, the current assault on Medicaid at the federal level suggests the value of building regional beachheads for a single-payer movement in the states. In New York, for example, this movement is already in progress and is providing lessons about the opportunities and challenges coalitions in other states will likely face.
- → Massive Medicaid cuts will not automatically generate anti-Republican political backlash. If anything, the opposite could be true. A sizable level of organizing will be required to leverage the current opportunity structure to defend and expand Medicaid post-Trump.

Introduction

Health care provision in the United States stands at a crossroads. As this paper goes to press, the Trump administration is launching an unprecedented assault on key public health insurance programs that will result in the loss of coverage for as many as 17 million people.[1] The bulk of the coverage loss will come in the form of cuts to Medicaid — the joint federal-state program that covers one in five Americans. This is the largest cut to Medicaid in the program's history, and is within the range of coverage losses the US would have experienced had Republicans successfully passed at least one of their proposals to repeal and replace the Patient Protection and Affordable Care Act (also known as Obamacare).[2] Republicans' 2025 budget reconciliation legislation, which will be enacted despite wide public disapproval, will have devastating effects on huge swaths of the American economy, including health care systems and rural hospitals.

In the face of these challenges, proponents of expanding and universalizing health coverage will be forced to confront a new strategic reality. Now that years of incremental expansions to a fundamentally fragmented and unequal health care system have redounded to rising prices, towering medical debt, dismal health outcomes, and bouts of retrenchment, there is no alternative to advancing the cause of universal health care. The only question is where to concentrate efforts to build up the political power of the working class to advance this cause.

This briefing paper argues that defense and expansion of Medicaid is the most promising focal point around which to coordinate working-class political mobilization towards delivering universal coverage. While the program's fragmented structure and means-tested design poses significant challenges for organizing a broad based and mobilized coalition, Medicaid has grown into both a cornerstone of the US health care system, and hence the American economy, as well as a lifeline for the working class. The

1. Cynthia Cox, "About 17 Million More People Could be Uninsured due to the Big Beautiful Bill and other Policy Changes," KFF, July 1, 2025, https://www.kff.org/quick-take/about-17-million-more-people-could-be-uninsured-due-to-the-big-beautiful-bill-and-other-policy-changes/

2. Daniel Béland, Philip Rocco, and Alex Waddan, "Policy Feedback and the Politics of the Affordable Care Act," *Policy Studies Journal,* 2019, vol. 47, pp. 395–422.

central argument advanced here is that Medicaid's internal contradictions can be leveraged to build a working-class coalition capable of advancing universal health coverage.

In searching for the seeds of a reform coalition, other strategies have focused on populations covered by the Affordable Care Act's individual marketplaces, which enroll a small percentage of the US middle class who lack access to employer-sponsored insurance, as well as the Medicare population, which largely lacks the structural power.[3] While no doubt useful, these approaches would do less to harness the latent political power of the mass working class than would a Medicaid-focused approach. In short, Medicaid's relationship to state economies and its significance for working-class communities — as both patients and workers in the health care sector dependent upon Medicaid funding — creates important opportunities for political organizing.

Linking the struggle of beneficiaries to that of health care workers is particularly important given that workers possess sources of structural power in the economy. And while Medicaid beneficiaries are typically harder to mobilize than the beneficiaries of other programs (given the class bias in the composition of the American electorate), the program's contradictions create mobilizing opportunities that have not yet been exploited. Medicaid occupies a different strategic position today than it did when the ACA was first passed. Following the passage of that law, millions of working-class Americans were added to the program's rolls. If the 2025 budget reconciliation bill is implemented as designed, those millions are now poised to experience losses in coverage. More than mobilizing these individuals to push for a restoration of benefits they have lost, there is an opportunity here to go further, building power to support non-reformist reforms.

This paper begins with a brief primer on Medicaid — including on its administrative structure and financing. The second section sketches out the political economy of Medicaid, dissecting the puzzle of how the program has grown despite the political demobilization of its own beneficiaries. Drawing on this analysis, the third section outlines a strategic framework for leveraging Medicaid's contradictions to build working-class power, connecting immediate defenses of the program to the longer-term goals of universal health coverage.

3. See Jacob S. Hacker, "Between the Waves: Building Power for a Public Option," *Journal of Health Politics, Policy and Law,* 2021, vol. 46, pp. 535–47.

A Brief Guide to Medicaid

Medicaid is best understood in the context of the fragmented US health care system of which it is a major part. Unlike many of its peers in the set of wealthy democracies, the United States lacks universal health insurance. In its place is an archipelago of public and private payers (see Table 1). Roughly 65 percent of Americans hold some form of private health insurance which is provided primarily via employers and, to a lesser extent, through non-group plans sold on government-run exchanges. 36 percent have insurance through a public payer, be it Medicare (a federal social insurance program for individuals 65 and older), Medicaid (a federal-state program that covers low-income and disabled Americans), or via a program run by the Department of Veterans Affairs (VA).

As comparative studies have shown, the fragmentation of payers increases costs and worsens the quality of care.[4] Yet it also has some notable political effects. On the one hand, the fragmentation of payers dilutes political accountability for rising care costs — robbing political movements of a valuable "focal point" (i.e. a single payer) on which to concentrate action. Equally importantly, the fragmentation of payers may prevent coalitions from forming in the first place. No two insurance plans present payers with the same set of costs and benefits. Moreover, payer fragmentation perpetuates the myth that "self-reliant," "able-bodied" workers do not, and should not, rely on public support for health coverage. In fact, however, virtually everyone who is insured in the United States relies on public support. The only difference is that the role of the state in subsidizing nominally "private" insurance is submerged in the tax code. In 2022 alone, the tax subsidy for employer-sponsored insurance cost the federal government an estimated $299 billion.[5] In the absence of these tax subsidies, commercial insurance would simply not be offered to the same extent.

4. Steffie Woolhandler, Terry Campbell, and David U. Himmelstein, "Costs of Health Care Administration in the United States and Canada," *New England Journal of Medicine,* 2003, vol. 349, pp. 768–75.

5. "How Does the Tax Exclusion for Employer-Sponsored Health Insurance Work?," Tax Policy Center, https://taxpolicycenter.org/briefing-book/how-does-tax-exclusion-employer-sponsored-health-insurance-work; Suzanne Mettler, *The Submerged State: How Invisible Government Policies Undermine American Democracy*, University of Chicago Press, 2011.

Table 1: Health Care Financing in the United States is Fragmented
Health care coverage in the United States by source, 2023

Source	Enrollment (millions / percentage of US population)
Private health insurance Employment-based	178.2 (54%)
Private health insurance Direct purchase	33.9 (10%)
Private health insurance TRICARE	8.7 (3%)
Medicare	62.5 (19%)
Medicaid/CHIP	62.7 (19%)
Military VA Care / CHAMPVA	3.2 (1%)
Uninsured	26.4 (8%)

Source: "Current Population Survey, 2023" and "2024 Annual Social and Economic Supplements" (CPS ASEC), US Census Bureau.
Note: Estimates by type of coverage are not mutually exclusive.

The Medicaid program is arguably the most dynamic — and most catalytic — component of the fragmented US health care regime. Initially designed as a modest program for people with disabilities and extremely low income, the program has grown in large part to fill in the gaps that have invariably opened up in Americans' access to health care.

What is Medicaid?

Jointly administered and financed by federal and state governments, the Medicaid program supports health coverage for roughly one in five people living in the United States. That includes one in six adults, four in ten children, eight in ten children in poverty, and six in ten nonelderly adults living in poverty. For over 78 million people, the program covers a wide array of services. Medicaid covers nearly half of all live births in the United States, services for five in eight people in nursing homes. 40 percent of nonelderly

adults with HIV are covered by Medicaid, as are nearly half of children with special health care needs.[6]

Enacted in 1965, Medicaid is a statutory entitlement program. Individuals are guaranteed coverage if they meet eligibility requirements. While the federal government sets minimum Medicaid eligibility standards, states may expand eligibility beyond them. For example, states must cover infants under the age of one up to at least 133 percent of the Federal Poverty Level (FPL), or a monthly income of $1,734.54 for an individual person.[7] Yet states can also expand coverage to infants in households making up to 185 percent FPL or higher. A full list of eligibility criteria and state expansion options is provided in Table 2.

Beyond variations in eligibility rules, state governments have some discretion with respect to the administrative procedures they employ when it comes to Medicaid applications and renewals.[8] For example, while some states have streamlined burdensome screening requirements, many other states require significant (and duplicative) documentation from pay stubs and other income verification materials, even when states have access to reliable data that can be used to confirm eligibility. Further, states have highly variable bureaucratic capacities for administering Medicaid programs. According to the National Association of Medicaid Directors, "the average Medicaid agency vacancy rate is 17 percent, although some states are as high as 30 to 40 percent."[9]

6. This section is heavily indebted to Robin Rudowitz, Jennifer Tolbert, Alice Burns, Elizabeth Hinton, and Anna Mudumala, "Medicaid 101." In Drew Altman (ed.), "Health Policy 101," KFF, May 28, 2024, https://www.kff.org/health-policy-101-medicaid/

7. "HHS Poverty Guidelines for 2025," Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, https://aspe.hhs.gov/sites/default/files/documents/dd73d4f00d8a819d10b2fdb70d254f7b/detailed-guidelines-2025.pdf

8. Donald P. Moynihan, Pamela Herd, and Elizabeth Ribgy, "Policymaking by Other Means: Do States Use Administrative Barriers to Limit Access To Medicaid?," *Administration & Society,* 2016, vol. 48, pp. 497–524.

9. Dawn Cutler-Tran, "Medicaid Agency Workforce Challenges and Unwinding," National Association of Medicaid Directors, March 10, 2023, https://medicaiddirectors.org/resource/medicaid-agency-workforce-challenges-and-unwinding/

Table 2: Despite Federal Requirements, Medicaid Eligibility Options Vary Across the Fifty States

Federal Medicaid eligibility requirements and state eligibility options

Mandatory Populations	Examples of Optional Populations
Poverty-related infants, children, and pregnant women and deemed newborns	Low-income children, pregnant women, and parents above federal minimum standards
Low-income families (with income below the state's 1996 Aid to Families with Dependent Children limit)	Elderly and disabled individuals with incomes above federal minimum standards or who receive long-term services and supports in the community
Families receiving transitional medical assistance	Medically needy (individuals with high medical expenses whose income is too high to qualify for standard Medicaid coverage but who may become eligible by "spending down" their excess income on medical costs.)
Children with Title IV-E adoption assistance, foster care, or guardianship care and children aging out of foster care	Adults without dependent children
Elderly and disabled individuals receiving SSI and aged, blind, and disabled individuals in 209(b) states	Home and Community-Based Services (HCBS) and Section 1115 waiver enrollees
Certain working individuals with disabilities	Enrollees covered only for specific diseases or services, such as breast and cervical cancer or family planning services
Certain low-income Medicare enrollees	Qualified immigrants who have been in the country for five years.

Source: "Federal Requirements and State Options: Eligibility," Medicaid and CHIP Payment and Access Commission, March 2017, https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Eligibility.pdf

Collectively, interstate variations in eligibility requirements, administrative burdens, and state capacity ensure that far fewer people are enrolled in Medicaid than are eligible for the program. Roughly one in four people under the age of 65 are eligible for either Medicaid or the Children's Health Insurance Program but are not enrolled for the program. Relatedly, in a typical year, roughly 10 percent of Medicaid beneficiaries

will be disenrolled at some point — a phenomenon known as "churn."[10] Often these disenrollments occur not because the beneficiary has become ineligible, but for procedural reasons such as incorrectly filing paperwork, missing a deadline, and so on. Given Medicaid's decentralized structure, gaps in eligibility, enrollment among eligible persons, and churn also vary considerably across states. As a quick snapshot of how Medicaid varies in reaching low- and moderate-income households, Figure 1 presents a scatterplot of the percentage of adults (ages 19–64) living below 200 percent of FPL ($31,300 for an individual in 2025) who lack Medicaid coverage and who lack any other source of health insurance. As is visible, Medicaid enrollment as a percentage of this population varies from 19 percent in Texas to 63 percent in the District of Columbia. By contrast, the percentage of the population who lack any source of insurance coverage ranges from 7 percent in Massachusetts to 39 percent in Texas. Unsurprisingly, the lower the rate of state Medicaid coverage for this population, the higher the state's uninsurance rate.

Figure 1: Medicaid Coverage Means Health Insurance

Medicaid access and uninsurance rates for adults (age 19–64) with household incomes below 200% FPL, by state (2023)

Source: Data drawn from KFF State Health Facts, https://www.kff.org/state-category/medicaid-chip/

10. Bradley Corallo, Rachel Garfield, Jennifer Tolbert, and Robin Rudowitz, "Medicaid Enrollment Churn and Implications for Continuous Coverage Policies," KFF, December 14, 2021, https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/

Table 3: Medicaid Benefits Vary Considerably Across the Fifty States
Examples of Mandatory and Optional Medicaid Benefits

Mandatory Medicaid Benefits	Optional Medicaid Benefits (Examples)
Transportation to medical care	Private duty nursing services
Inpatient hospital services	Clinic services
Rural health clinic services	Dental services
Federally qualified health center services	Physical therapy
Laboratory and X-ray services	Occupational therapy
Nursing facility services	Speech, hearing, and language disorder services
Early and periodic screening, diagnostic, and treatment (EPSDT) services	Prescription drugs
Family planning services	Prosthetics
Tobacco cessation counselling for pregnant women	Eyeglasses
Physician services	Services in an intermediate care facility for individuals with intellectual disability
Home health services	Inpatient psychiatric services for individuals under 21
Nurse midwife services	Hospice
Certified paediatric and family nurse practitioner services	Case management
Freestanding birth centre services when licensed or otherwise recognised by the state	TB-related services
Medication assisted treatment (MAT)	Respiratory care for ventilator-dependent individuals

	Personal care
	Primary care case management
	Primary and secondary medical strategies, treatment, and services for individuals with sickle cell disease
Self-directed personal assistance services	
	Certified community behavioral health clinic (CCBHC) services
	Home and community-based services

Source: "Mandatory & Optional Medicaid Benefits," Medicaid.gov, https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits

Just as states have some discretion over Medicaid eligibility, they also have some flexibility in what benefits their state Medicaid program covers. As Table 3 shows, states are required to cover over a dozen categories of services under Medicaid. This includes long-term care delivered in nursing facilities and via home health aides, as well as acute care benefits ranging from inpatient and outpatient hospital services to certified pediatric and family nurse practitioner services. However, there are at least two dozen categories of services that states are not required to provide. On the acute side, this includes dental care, prescription drugs, physical therapy, and vision care. The optional character of these services results in significant interstate variation. While 39 of 50 states cover dental services under Medicaid, 19 require a copayment, and a number of states require prior authorization for these services.[11] Where long-term care is concerned, home- and community-based services (HCBS) are also optional. Thus, while all states have at least one HCBS waiver, the services offered under those waivers vary considerably across states and waiver programs. For example, fewer than half of the HCBS waivers for medically fragile or technology dependent children offer day services or nursing or therapy services.[12]

11. "Medicaid Adult Dental Benefits Coverage by State," Centre for Healthcare Strategies, https://www.chcs.org/media/Medicaid-Adult-Dental-Benefits-Overview-Appendix_091519.pdf.

12. MaryBeth Musumeci, Molly O'Malley Watts, and Priya Chidambaram, "Key State Policy Choices About Medicaid Home and Community-Based Services," KFF, February 2020, https://files.kff.org/attachment/Issue-Brief-Key-State-Policy-Choices-About-Medicaid-Home-and-Community-Based-Services

Who pays?

Decisions about Medicaid financing are made by both federal and state governments. The bulk of financing for the program comes from the federal government via general revenues.[13] In fiscal year 2025, the federal government paid an average of 60 percent of all Medicaid costs in each state. In practice, the extent of most federal financing hinges on a redistributive matching formula called the Federal Medical Assistance Percentage (FMAP), which allocates a greater share of federal spending to states with lower relative per capita household incomes. The statutory floor for FMAP is fifty percent, meaning that in states with relatively high per capita incomes (e.g. California and Colorado), the federal government covers half of all Medicaid costs. By contrast, in states with relatively low per capita incomes, such as West Virginia and Mississippi, FMAP rates are considerably higher (74 and 77 percent), respectively. The maximum FMAP rate is 83 percent, currently in place in four of five unincorporated US territories (American Samoa, Guam, the Northern Mariana Islands, and the US Virgin Islands).[14]

To entice states to expand Medicaid coverage, the federal government can offer enhanced FMAP rates. For example, when the Patient Protection and Affordable Care Act (alias Obamacare) expanded Medicaid coverage to new adult beneficiaries whose annual incomes were up to 138 percent FPL, the federal government covered 100 percent of the costs for these individuals between 2014 and 2016, phasing down to 90 percent in 2020 and subsequent years.[15] When the US Supreme Court held that Medicaid expansion was not mandatory in *NFIB v. Sebelius* (2012) and that states could decide whether to opt in, this windfall nevertheless provided a powerful incentive for states to expand coverage. To date, all but ten states have implemented Medicaid expansion.[16]

13. This is one feature that distinguishes Medicaid from Medicare, the health care program that supports most people in the US over the age of 65, which is financed primarily through dedicated revenue sources (e.g. the payroll tax) and beneficiary premiums.

14. "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier," KFF, FY2025, https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=1&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

15. Matthew Buettgens, "Reducing Federal Support for Medicaid Expansion Would Shift Costs to States and Likely Result in Coverage Losses," Urban Institute, February 2025, https://www.urban.org/research/publication/reducing-federal-support-medicaid-expansion-would-shift-costs-states-and-coverage-losses

16. "Status of State Medicaid Expansion Decisions," KFF, May 9, 2025, https://www.kff.org/status-of-state-medicaid-expansion-decisions/?gad_source=1&gad_campaignid=928496071&gbraid=0AAAAAD-0VUfWe9xeUZ47PiRvrf2rvXlUC&gclid=Cj0KCQjwjo7DBhCrARIsACWauSmCzKchiADOIv72I6-GfjAJ8nYgRukubbqe1Y005bTwEr_6yTvlxzIaAr-hEALw_wcB

The nonfederal share of Medicaid funds comes from a mix of sources. Federal statutes require at least 40 percent of the nonfederal share to be provided by state governments, while the remaining 60 percent can come from a combination of intergovernmental transfers from local governments or through certified public expenditures by hospitals or health systems owned by local governments. In fiscal year 2024, the bulk of state nonfederal contributions (nearly 70 percent) came from state general revenues, with the remaining funding coming from other sources including local government funds and taxes on providers.[17]

How is Medicaid delivered?

Under federal rules, states have the flexibility to provide medical insurance services via a diverse array of delivery systems, which can vary not just by state but within states between different Medicaid populations. Fee-for-service systems — in which states directly manage beneficiary enrollment, provider payment, and daily operations — were once dominant in Medicaid. This is not so today. At present, less than a quarter of Medicaid beneficiaries are enrolled in fee-for-service plans. By contrast, since the 1990s, Medicaid has been increasingly penetrated by the Managed-Care Organization (MCO) model, in which states contract with private insurance companies to carry out the basic operations of the Medicaid program, ranging from enrollment and plan management to provider payment.[18]

Today, well over 60 percent of Medicaid beneficiaries are enrolled in MCOs. Under this model, states pay MCOs a flat fee per member per month (known as a "capitated payment").[19] MCOs are responsible for the cost of all services the enrollees need but can pocket the savings if costs are less than the capitated payment. Providers, in turn, both enroll in the state Medicaid program but must also contract with MCOs, to whom they submit claims. MCOs are often not required to accept any willing provider and can limit provider networks.

Relatedly, half of Medicaid beneficiaries are also enrolled in limited benefit plans that cover services like dental and vision care, as well as medical transportation. These plans operate on a basis similar to that

17. "2024 State Expenditure Report," National Association of State Budget Officers, https://www.nasbo.org/reports-data/state-expenditure-report.

18. Andrew S. Kelly, "Private Power in Public Programs: Medicare, Medicaid, and the Structural Power of Private Insurance," *Studies in American Political Development,* 2023, vol. 37, pp. 24–40.

19. "December 2024 Report," Medicaid and Chip Payment and Access Commission, https://www.macpac.gov/wp-content/uploads/2024/12/EXHIBIT-30.-Percentage-of-Medicaid-Enrollees-in-Managed-Care-by-State-and-Eligibility-Group-FY-2022.pdf

of MCOs. States contract with private companies, and make capitated per-member-per-month payments. Private companies — who bear responsibility for costs in excess of the capitated payments but can keep savings — meanwhile make contracts with providers.

What do we know about provider access and health outcomes?

Most US health care providers — nearly three quarters according to one national analysis — accept new patients insured by Medicaid. For some types of providers, this figure is even higher. For example, 100 percent of family-planning clinics reportedly took on new Medicaid patients, as did over 97 percent of community health centers, and 95 percent of physicians in faculty practices. Nevertheless, especially given relatively low reimbursement rates, the percentage of physicians who accept Medicaid is often lower than in Medicare (upwards of 85 percent) or private insurance (roughly 90 percent). Acceptance of Medicaid coverage by providers also varies considerably by state. The same analysis identified fifteen states in which over 90 percent of physicians accepted new Medicaid-insured patients. In eight states, fewer than 70 percent of physicians reportedly did the same. [20] Of course, even on the private side of the payer spectrum, where the provider acceptance rate is relatively, few providers accept coverage from *all* payers, especially as the number of "narrow network" plans has risen in recent decades.

While reimbursement rates may help to produce an undersupply of care in some places, there is an abundance of research on the positive health benefits of Medicaid coverage. One reason for this is that the program's decentralized design — while locking in deep interstate inequalities — has also created a robust industry of research, which leverages that variation to examine the effects of Medicaid expansion on a range of health outcomes. If research alone drove policy, this body of knowledge would constitute a significant brief in favor of universal health insurance in the United States. One recent study on mortality rates among adults is illustrative. Medicaid expansion following the Affordable Care Act (ACA) led to a 12 percent increase in enrollment and significantly reduced mortality among low-income adults by 2.5 percent, or 27,400 lives saved between 2010 and 2022. This represents a 21 percent decrease in the mortality hazard for enrollees.

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

Had all states expanded Medicaid, an additional 12,800 deaths could have been prevented.[21] Beyond reduced mortality, the most comprehensive reviews of research suggest that Medicaid coverage has been associated with, among other outcomes: improved cancer survival rates, improved management of chronic disease, reduced hospital length-of stay, and lower levels of in-hospital mortality.[22]

21. Angela Wyse and Bruce D. Meyer, "Saved by Medicaid: New Evidence on Health Insurance and Mortality from the Universe of Low-Income Adults," No. w33719, National Bureau of Economic Research, 2025.

22. See, generally, Madeline Guth, Rachel Garfield, and Robin Rudowitz, "The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review," KFF, March 2020, https://files.kff.org/attachment/Report-The-Effects-of-Medicaid-Expansion-under-the-ACA-Updated-Findings-from-a-Literature-Review.pdf

The Political Economy of Medicaid

Medicaid is defined by a set of interlocking contradictions. First, despite massive growth in enrollment over the last half-century, the program's primary beneficiaries are often politically demobilized. Medicaid, in turn, remains vulnerable to benefit retrenchment and austerity. Second, Medicaid is one of the largest public payers in the US health care system, but it has been thoroughly penetrated by private corporations and market logics. Third, while Medicaid has incrementally grown into a middle-class entitlement — synonymous with "health insurance" — politicians and political observers still refer to it in using the stigmatizing language of "welfare medicine." This section sketches out the political economy of Medicaid, unpacking each of these contradictions along the way.

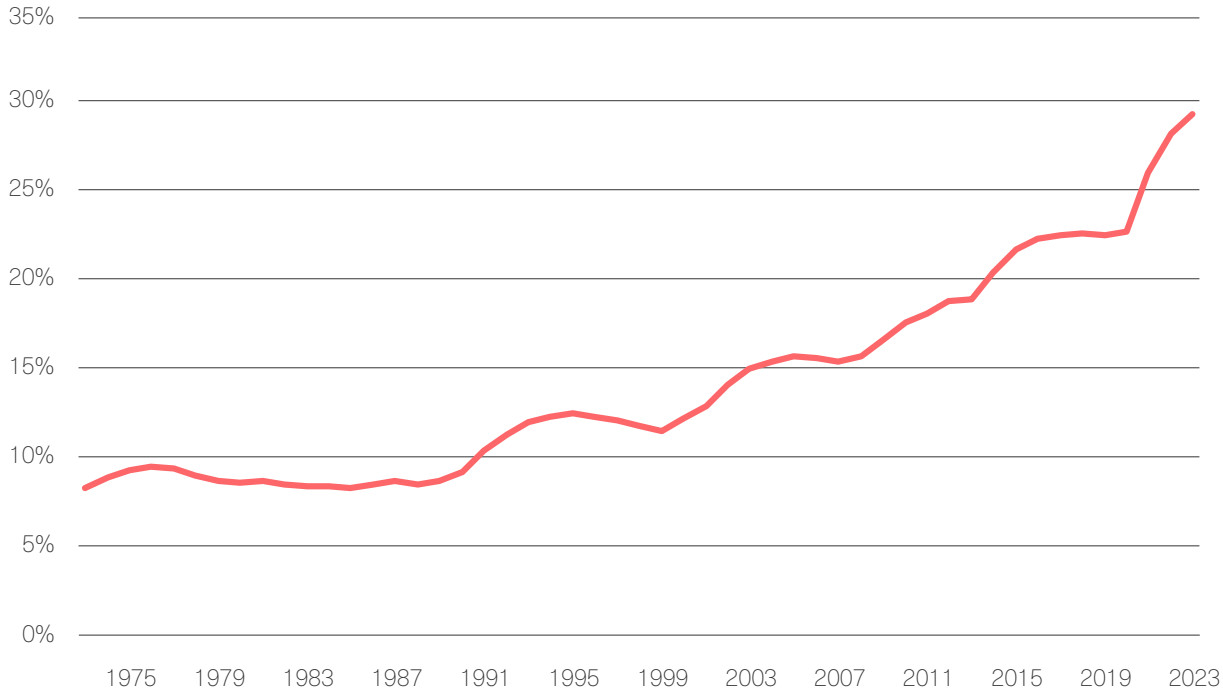
The arc of growth

When Medicaid was created by Congress in 1965, few observers believed it would grow into what it is today — a source of health insurance for one in five Americans, often the largest share of state budgets, and a substantial engine of the US economy, with a pronounced "multiplier effect," in which each dollar of spending generates more than a dollar's worth of economic activity. At its inception, eligibility for the program was limited to a small number of people, composed primarily of individuals with disabilities, and women and children who qualified for what was then Aid to Families with Dependent Children (AFDC). Because program operations hinged on voluntary participation by state governments, the program rolled out far more slowly and subtly than Medicare, a uniform federal program that covered all eligible seniors. By 1968, three years after its inception, 38 states and three territories had initiated Medicaid programs.[23]

23. "Intergovernmental Problems in Medicaid," US Advisory Commission on Intergovernmental Relations, 1968, https://library.unt.edu/gpo/acir/Reports/policy/A-33.pdf

Figure 2: Medicaid Coverage Has Grown Considerably since the 1970s

Percent of US population covered by Medicaid, 1973–2023



Source: Adapted by author from "Medicaid Enrollment and Total Spending Levels and Annual Growth," Medicaid and CHIP Payment and Access Commission, December 2024, https://www.macpac.gov/publication/medicaid-enrollment-and-total-spending-levels-and-annual-growth/

Over the three decades that followed its passage, however, Medicaid experienced a startling transformation (see Figure 2). As the result of state initiatives, eligibility for the program and the scope of services it covered gradually expanded; enrollment in Medicaid doubled in size. What began as so-called "welfare medicine" suddenly began — for reasons we soon will see — to approach the status of a middle-class entitlement. Indeed, unlike other social programs directed primarily at the poor, Medicaid survived the social policy retrenchment efforts of the 1980s and 1990s and stands today as a programmatic colossus, the largest single transfer from the federal to state governments, and often the largest sources of revenue and expenditure activity for many states. This scale, however, conceals a variety of contradictions that haunt Medicaid's political economy.

Medicaid's widening sphere of beneficiaries and its increasingly integral role in state economies no doubt made it politically durable. But, in contrast to Medicare — the social insurance program for Americans 65 and older, which has long been seen as a "third rail" which politicians tamper with at their own peril — Medicaid's growth and endurance have not sanctified the program. Even if its prodigious size and economic reach increase the political costs of some proposals to unmoor the program,

Medicaid is not immune to such threats.[24] Congressional proposals to cut federal Medicaid funding have been a perennial feature of the Republican Party's national agenda. These include frontal assaults (the conversion of Medicaid from an entitlement into a block grant, or capped per capita payments to states). They also include stealthier maneuvers aimed at limiting states' flexibility in financing the nonfederal share of Medicaid payments (e.g. by capping or restricting the use of provider taxes). Perhaps most prominently, proposals to cut Medicaid have aimed to catalyze disenrollment through the imposition of new administrative burdens on Medicaid enrollees, frequently — though not exclusively — in the form of work requirements.[25]

While most Medicaid beneficiaries who are able to work already do, these proposals — which often attract surface-level public support — play on the specter of illegitimacy that haunts many if not most means-tested programs that benefit impoverished Americans. In practice, work requirements have no measurable effect on employment and instead can be counted on to result in massive disenrollment from Medicaid, often for purely procedural reasons. The Trump administration's 2018–19 policy of allowing states to "experiment" with work requirements in Medicaid via a demonstration program provides a useful example. Prior to being struck down in federal court, the state of Arkansas implemented work requirements, resulting in the disenrollment of 18,000 beneficiaries — the vast majority of whom were disenrolled for purely procedural reasons rather than a lack of eligibility, since they were either working or exempt from work requirements.[26]

Following their years in gestation during the first Trump administration, work requirements and other procedural maneuvers to cut Medicaid became central to the current Trump administration's budget reconciliation package in 2025. As a result of the combination of new requirements, caps on provider taxes in the states, and other new changes to the Affordable Care Act marketplaces, the legislation is expected to increase the ranks

24. See, e.g., Frank Thompson, *Medicaid Politics,* Georgetown University Press, 2013; Colleen Grogan, *Grow and Hide: The History of America's Health Care State,* Oxford University Press, 2023.

25. In the 2025 budget reconciliation legislation, only 31 percent of Medicaid-related coverage losses can be attributed to work requirements. The remainder can be attributed to, among other things, a repeal of rules that simplify eligibility and renewal procedures, an increase in the frequency of eligibility checks, limits on states' ability to levy provider taxes, and limited payments to providers. See, e.g. "Letter Re: Estimated Effects on the Number of Uninsured People in 2034 Resulting From Policies Incorporated Within CBO's Baseline Projections and H.R. 1, the One Big Beautiful Bill Act," Congressional Budget Office, June 4, 2025, https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf

26. Benjamin D. Sommers, Lucy Chen, Robert J. Blendon, E. John Orav, and Arnold M. Epstein, "Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care", *Health Affairs,* 2020, vol. 39, pp. 1522–30.

of the uninsured by 17 million by 2034. Taken together, these changes will also reduce Medicaid spending by $1 trillion. That sum is significant in part because Medicaid cuts are designed to partially extend tax cuts that will increase the income of the top 1 percent of earners by 2 percent.[27]

At the federal level, Democrats have both defended Medicaid against these attacks and acted as the primary agents of expanding Medicaid eligibility, with the most notable episodes being the passage of the Children's Health Insurance Program (CHIP) in 1997 and the expansion of Medicaid as part of the Affordable Care Act in 2010.[28] Though these expansions have extended Medicaid eligibility into the ranks of the lower-middle class, they have done so while leaving intact both the program's means-tested logic and the overarching idea that private insurance is the normative standard for working adults. This choice can be found in the text of the ACA itself, which allows states to expand Medicaid eligibility up to 138 percent of the FPL. By contrast, households with incomes between 138 percent and 400 percent FPL are provided with tax subsidies for the purchase of private insurance. There is no evidence that Democratic leaders are eager to upend these bifurcated arrangements. In the years that followed the COVID-19 pandemic, Democrats made little effort to make permanent temporary emergency expansions of Medicaid, which took the form of enhanced payments to states as well as continuous eligibility requirements. Doing so would have required rethinking the program's logic of means testing, which enables enrollment to expand during economic crises and contract during recoveries. No policy proposals of this sort emerged during the waning years of the Biden administration. As it was, the administration focused its attention on administrative measures that would cushion the blow of the so-called "unwinding" of Medicaid. Of the 25 million Americans who lost Medicaid coverage during the unwinding, 70 percent lost coverage for procedural reasons rather than ineligibility.[29]

27. "Distributional Effects of Selected Provisions of the House and Senate Reconciliation Bills," Yale Budget Lab, June 30, 2025, https://budgetlab.yale.edu/research/distributional-effects-selected-provisions-house-and-senate-reconciliation-bills

28. Colleen M. Grogan and Elizabeth Rigby, "Federalism, Partisan Politics, and Shifting Support for State Flexibility: The Case of The US State Children's Health Insurance Program," *Publius: The Journal of Federalism,* 2009, vol. 39, pp. 47–69; Colleen M. Grogan, "Medicaid's Political Development since 1965: How a Fragmented and Unequal Program Has Expanded," *Journal of Health Politics, Policy and Law,* 2025, vol. 50, pp. 137–64.

29. "Medicaid Enrollment and Unwinding Tracker," Kaiser Family Foundation, July 2, 2025, https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-unwinding-tracker/. In the run up to a critical presidential election year, these coverage losses could have had significant impacts in tightly contested swing states. As one study from prior years suggests, for every one percentage-point drop in Medicaid enrollment, voter turnout decreased up to a third of a percentage point. Jake Haselswerdt and Jamila Michener, "Disenrolled: Retrenchment and Voting in Health Policy," *Journal of Health Politics, Policy and Law,* 2019, vol. 44, no. 3, pp. 423–54.

The political logic of growth

Medicaid's prodigious growth and durability has thus occurred within an institutional framework that reinforces conservative premises about the appropriate shape of the welfare state.[30] To account for this, we must consider how Medicaid's design structured the course of the program's development.

Congress crafted Medicaid as a targeted, means-tested program, a feature which placed some notional upper bounds on eligibility and invited the political attacks that are frequently visited upon programs that benefit the poor. Yet at the same time, the program was run by state governments, which had significant discretion in the definition of the target population, as well as strong fiscal incentives for expansion. The program's generous matching formula — through which the federal government picked up a substantial share of the costs of Medicaid provision — allowed state lawmakers to extend benefits and reap the gains of economic growth without commensurate increases in general taxation. This design, as economists noted, created a "substitution" effect, lowering the cost of offering Medicaid services for states and incentivizing higher levels of spending on the program than would exist if it were structured as a block grant in which payments do not hinge on the amount of state spending.[27]

Thus, even if they could not quickly refashion Medicaid into a middle-class program, governors and state legislators could expand coverage to people who might have had medical needs but fell outside the traditional definitions of poverty. As early as 1967, states like New York did exactly this. In subsequent decades, governors leveraged Medicaid's decentralized structure and generous fiscal arrangements to expand coverage to new populations ranging from children and mothers to individuals with AIDS and breast cancer. In the 1980s, the National Governors Association (NGA) played a key role in lobbying to expand federal support for Medicaid coverage to children — an effort which, after years of incremental change, culminated in the creation of CHIP in 1997. While officials in some states publicly groused about the addition of new coverage mandates, the fiscal arrangement made it far less expensive for states to offer these benefits through Medicaid rather than other state-level safety-net programs.[31]

By the 1980s, new coverage gaps were also beginning to emerge that helped to fuel Medicaid growth. One of these gaps emerged because Medicare, which had become the primary source of health insurance for

30. Grogan, *Grow and Hide.*

31. Thompson, *Medicaid Politics.*

persons over the age of 65, did not cover long-term services and supports (LTSS) for older persons and those with disabilities. As repeated efforts to expand that program to accommodate long-term care failed, Medicaid became the "de facto" source of LTSS insurance for a growing share of the middle-class, who were forced to spend down their assets to meet the program's exacting means test. By 1997, Medicaid spending on nursing homes neared $40 billion per year — nearly half of all nursing home expenditures in the United States.[32]

A second coverage gap emerged due to changes in the landscape of private benefits. As the US health care system was constructed during and after the Second World War, its underlying premise was that employers would be the primary source of insurance for working Americans under the age of 65. Indeed, heavy federal tax subsidies underwrote the provision for employer-sponsored plans. Yet beginning in the 1980s, this system began to come apart thanks to rising medical costs, a segmenting risk pool, and the decline of organized labor. The percentage of persons enrolled in employer-sponsored insurance thus peaked in 1980 and fell by double digits over the subsequent decades.[33] By 1992, public demand for the federal government to confront this crisis of rising uninsurance had reached a fever pitch.

By 1993, the Clinton administration had tried to convert these demands into a push for a version of universal health coverage. Yet, to maneuver through the gauntlet of deficit-neutrality rules and austerity procedures that had been created in the late 1980s, the Clinton administration fashioned a proposal laden with "regional health alliances, contingent premium caps, and all sorts of charges to 'recapture' private-sector health savings for the federal budget."[34] In the end, this complex mélange attracted few enthusiastic supporters, while creating a perfect opportunity for private insurers to shoot down the proposal by invoking public fears of unwieldy, choice-constraining government bureaucracy.

In the wake of this policy failure, the gradual expansion of Medicaid continued throughout the 1990s and 2000s via state government waivers and demonstrations as well as Congress's creation of CHIP in 1997. Yet these expansions also involved two additional transformations of Medicaid. First, thanks to regulatory changes in the 1990s, state Medicaid provision

32. Grogan, "Medicaid's Political Development Since 1965."

33. Jacob S. Hacker, *The Divided Welfare State: The Battle Over Public and Private Social Benefits in the United States,* Cambridge University Press, 2002, p. 260; Robin A. Cohen, Diane M. Makuc, Amy B. Bernstein, Linda T. Bilheimer, and Eve Powell-Griner, "Health Insurance Coverage Trends, 1959-2007: Estimates from the National Health Interview Survey," *National Health Statistics Reports,* 2009, vol. 17, pp. 1–25.

34. Martin Halpern, *Unions, Radicals, and Democratic Presidents* (Westport, CT: Prager, 2003), p. 205.

became increasingly penetrated by private MCOs (see above) which politicians had promised would simultaneously restrain program costs while erasing the idea that Medicaid was charity care, since patients would now be enrolled in plans managed by large private insurance carriers. Along with this, and ostensibly to destigmatize Medicaid recipients, a number of states rebranded their new Medicaid expansion programs into unique state-focused names (BadgerCare in Wisconsin, Medi-Cal in California, and so on).[35]

Whose Medicaid?

These changes had several distinct effects on the politics of Medicaid. First, the introduction of MCOs created new political constituencies for the program, including both insurers and private equity (PE) firms. Medicaid now represented a stable source of public revenue for a market composed of a small number of large firms (Centene, Molina, Anthem, UnitedHealth, Molina, and Aetna/CVS held the largest Medicaid market shares). Along with governors and hospital systems, PE firms now depend on Medicaid dollars to deliver returns on investment for the growing share of facilities they have purchased. The privatization of Medicaid service delivery also gave MCOs a unique form of structural power, allowing insurers to threaten that efforts to discipline rent-seeking behavior or enforce more stringent quality standards would result in harm and service disruption.[36] With the growth in Medicaid spending — set to continue apace given the aging American population — private equity increasingly eyed investments in health care. By ensuring a steady stream of revenue in services with steady demand, Medicaid made investments in hospitals and health systems increasingly attractive for PE. Private equity's growing presence in the health care sector — aided by a suite of federal and state policy decisions — resulted in notable deteriorations in the quality of care at the hands of profit-maximization techniques.[37]

Second, despite promises of destigmatization, these changes did little to enhance beneficiaries' political agency. While there is no evidence that the "managed care revolution" led to cost-efficiencies or reduced stigma, it nevertheless masked the role of government in the provision of Medicaid. Further, to the extent that cost controls resulted in a more limited

35. Andrew S. Kelly, "Private Power in Public Programs"; Adrianna McIntyre, Josh McCrain, and Danielle Pavliv, "Medicaid by Any Other Name? Investigating Malleability of Partisan Attitudes toward the Public Program," *Journal of Health Politics,* Policy and Law, 2024, vol. 49, pp. 451–71.

36. Andrew S. Kelly, "Private Power in Public Programs."

37. See Laura Katz Olson, *Ethically Challenged: Private Equity Storms US Health Care,* JHU Press, 2022.

package of services, it redounded to the demobilization of beneficiaries. Whereas other programs, such as Social Security,[38] have been associated with greater voting, canvassing, participation, and other political activities, negative experiences with Medicaid (far more prone to disenrollments and other stigmatizing interactions with state officials), tended to have the opposite effect. As the political scientist Jamila Michener has shown, Medicaid beneficiaries living in states with stingy benefit packages are less likely to register to vote and to participate in politics when compared to their peers in states with more generous programs.[39] This is compounded by other structural factors — notably poverty — that tend to depress political engagement.

Survey evidence also suggests that the rebranding of Medicaid at the state level caused greater confusion among beneficiaries and failed to yield any gains in public support for the program.[40] If anything, the combination of rebranding and privatization further preempts Medicaid beneficiaries from developing a coherent political formation. Beneficiaries are first divided along state and territorial lines into 57 distinct programs. Within states and territories, they are further divided by their specific eligibility category. In Wisconsin, for example, there are roughly two dozen separate programs, each of which serves a unique population of children, working adults, the disabled, or the elderly.[41]

In the absence of beneficiary mobilization, the political arena of Medicaid is dominated by policy elites and mediated by the incentives and demands of governors, insurers, and health care systems. The advocacy groups that do represent Medicaid beneficiaries are, for the most part, organizations without members. Taken together, this interest-group landscape closes off opportunities for converting Medicaid into a more universal program — to say nothing of reconfiguring the US health system into a social insurance model. Nevertheless, as I argue in the next section, these problems are not insoluble.

38. Andrea Louise Campbell, *How Policies Make Citizens: Senior Political Activism and the American Welfare State*, Princeton University Press, 2003.

39. Jamila Michener, *Fragmented Democracy: Medicaid, Federalism, and Unequal Politics,* Cambridge University Press, 2018.

40. McIntyre, McCrain, and Pavliv, "Medicaid by Any Other Name?"

41. "Medicaid in Wisconsin," Wisconsin Department of Health Services, https://www.dhs.wisconsin.gov/medicaid/index.htm

A Window of Opportunity?

As noted above, Medicaid's institutional structure has created significant challenges for beneficiary organizing. Fragmentation across 57 programs, division by eligibility categories, privatization that obscures government responsibility, and the dominance of elite policy networks have locked the Medicaid coalition into a defensive posture that can, at best, only articulate support for gradual extensions of the program rather than universalizing reforms. This arrangement also leaves Medicaid vulnerable to periodic retrenchments, often in the guise of administrative burdens (e.g. work requirements), and cuts that pit one beneficiary population against another.

Despite these challenges, Medicaid has tremendous political potential. It reaches into the ranks of the working class as almost no other public program does. This population now includes 30 million adults aged 19–64, totaling nearly 17 percent of the nonelderly adult population. These are often workers in low-wage jobs whose employers do not provide health insurance. Perhaps most importantly, it provides public insurance to these individuals. The program attracts broad public support. Over 80 percent of American voters have a favorable view of the program. Half of Americans say they or a family member have been covered by Medicaid. Virtually all say the program is important for people in their communities, and fewer than twenty percent want to see cuts to Medicaid. In short, the program's reach and its public support should help to underwrite organizing beneficiaries around universal reform.[42]

The program has also generated tremendous bursts of political organizing. In every state that placed the question of Medicaid expansion before voters in ballot initiatives, the measure succeeded — often by wide margins, including in counties that routinely return Republican candidates to office. In these states, organizers launched Get Out the Vote campaigns that reached across the urban-rural divide in states like Maine, Utah, and Idaho. In all but a handful of counties across the country, votes for

42. "7 Charts About Public Opinion on Medicaid," KFF, June 17, 2025, https://www.kff.org/medicaid/poll-finding/7-charts-about-public-opinion-on-medicaid/

Medicaid expansion vastly outstripped support for Democratic presidential candidates.[43]

Medicaid's capacity to mobilize the working class helps to explain why the program, and particularly the ACA's expansion of it, remain in the Republicans' crosshairs. The partisan, ideological conflict over Medicaid can best be thought of as a war not so much over the program's scope or size but rather its capacity to unleash policy feedback that leads to working-class mobilization, especially mobilization for universal health insurance. Even if Medicaid cannot be easily converted into "welfare medicine" once again, it can nevertheless be restructured into a form of state-subsidized commercial coverage, complete with premiums and cost sharing — reinforcing the notion that private coverage is the ideal end-state of health provision. How then to harness massive Medicaid cuts as a tool for political organizing?

Linking beneficiaries to care workers and communities

Medicaid's transformation into a cornerstone of state economies creates unprecedented opportunities for beneficiary organizing. With the program constituting the largest federal transfer to states and often the largest component of state budgets, Medicaid beneficiaries possess latent structural power that can be activated through strategic campaigns. As I have argued elsewhere, program beneficiaries lack important power resources that both capital and labor possess.[44] The key insight, however, is that threats to Medicaid enrollment — whether through work requirements, administrative burdens, or funding cuts — represent threats to entire state economies, creating potential alliances between beneficiaries and other economic actors, including both care workers and the communities served by Medicaid-financed health care systems.

Given the "multiplier effect" of Medicaid spending — in which each dollar generates more than a dollar's worth of economic activity — organizing must better link beneficiary mobilization to broader economic coalitions. Unions representing workers in the health care sector, which depends on Medicaid reimbursements for financial viability, represent natural allies, particularly in rural areas where Medicaid expansion has

43. Gabrielle Gurley, "How Maine's Medicaid Expansion Campaign Got to Yes," *The American Prospect*, November 13, 2017, https://prospect.org/health/maine-s-medicaid-expansion-campaign-got-yes/; Philip Rocco, "Direct Democracy and the Fate of Medicaid Expansion," JAMA Health Forum 2020, vol. 1, p. e200934.

44. Philip Rocco, "Why the Democrats Are So Useless," *Catalyst*, 2025, vol. 9, pp. 9–43.

prevented hospital closures. Indeed, nurses' unions already routinely take an active part in defending Medicaid against cuts as well as leading movements for universal health insurance.[45] A coalition between beneficiaries and workers would help to expand the conflict beyond the industrial players who currently dominate Medicaid politics. Similarly, the growing dependence of nursing homes on Medicaid funding creates opportunities for linkages between working-age beneficiaries and families with elderly relatives requiring long-term care. Finally, Medicaid's pivotal role in supporting rural health systems means that cuts to the program will affect not just beneficiaries, but virtually ***all*** residents of rural communities, which are home to roughly 20 percent of the US population.[46] In anticipation of the passage of the 2025 Medicaid budget cuts, rural health clinics in states like Nebraska were already beginning to close their doors.[47]

One Medicaid: Building cross-program solidarity

In addition to lacking sources of structural power, a second roadblock to organizing is the division of Medicaid beneficiaries across multiple eligibility categories and state programs. Effective beneficiary organizing must therefore seek to unite different categories of beneficiaries around shared experiences of administrative burden, inadequate provider access, and threats to coverage. These formations must be explicitly designed to counteract the program's fragmentary effects by emphasizing common interests over categorical differences. State governments could ostensibly aid in this effort by ensuring that the branding of programs for unique populations continuously reinforce that each program is, in fact, Medicaid. The battles over Medicaid expansion at the ballot box provide examples of this. While hospitals and health systems were no doubt important in funding campaigns to support Medicaid expansion, community-based canvassing efforts by cross-cutting networks of organizations were pivotal in running up the vote tally.[48]

45. "Registered Nurses to Rally Against Medicaid Cuts in Reconciliation Package at Congressional District Offices," National Nurses United, June 27, 2025, https://www.nationalnursesunited.org/press/registered-nurses-to-rally-against-medicaid-cuts-in-reconciliation-package; "More than 500 Nurses Push Back Against Medicaid Cuts on Capitol Hill," American Nurses Association, June 26, 2025, https://www.nursingworld.org/news/news-releases/2025/nurses-push-back-against-medicaid-cuts-hill-day-2025/

46. Heather Saunders, Alice Burns, and Zachary Levinson, "How Might Federal Medicaid Cuts in the Senate-Passed Reconciliation Bill Affect Rural Areas?," KFF, July 2, 2025, https://www.kff.org/policy-watch/how-might-federal-medicaid-cuts-in-the-senate-passed-reconciliation-bill-affect-rural-areas/

47. Joseph McCarty, "Rural Southwest Nebraska Clinic Closes, Blaming Expected Medicaid Cuts," KLKN, July 3, 2025, https://www.klkntv.com/rural-southwest-nebraska-clinic-closes-blaming-expected-medicaid-cuts/

48. Robert Pear, "Medicaid Expansion Finds Grass-Roots Support in Conservative Utah," *New York Times*, September 9, 2018, https://www.nytimes.com/2018/09/09/us/politics/utah-medicaid-expansion.html

Broader efforts at community based-organizing in Medicaid face no shortage of challenges, ranging from inadequate funding to elites' deployment of partisan and racial identities to divide beneficiaries from one another.[49] Nevertheless, neighborhood-based organizing strategies — which explicitly target census tracts with large concentrations of beneficiaries — have the potential to unite Medicaid beneficiaries across eligibility categories while connecting them to broader community struggles around housing, education, and economic development. This approach recognizes that Medicaid beneficiaries are embedded in working-class communities facing multiple forms of economic insecurity, creating opportunities for multi-issue organizing that situates health care within broader struggles for economic justice.[50]

Given Medicaid's decentralized design, arguably the most significant challenge here will be linking grassroots efforts across states into the kind of federated structure that is typically associated with major federal policy changes. The stark variations in Medicaid eligibility and generosity across states divide beneficiaries from one another. Nevertheless, networks of grassroots organizers can identify common interests in federal program changes and can help beneficiaries in restrictive states to learn from and coordinate with their counterparts in more generous states. This approach requires building organizational infrastructures that can sustain cross-state communication and coordination while pressuring laggard states to adopt more generous policies. The successful campaign for Medicaid expansion through ballot initiatives in conservative states demonstrates this potential for interstate learning and coordination.[51]

Confronting privatization

If the years since the ACA's Medicaid expansion have demonstrated anything, it is that widening the scope of eligibility and improving the quality of Medicaid services can strengthen the resources and incentives for organizations seeking to mobilize the working class. Equally importantly, incremental expansions and the reduction of administrative burdens

49. Jamila Michener, "Building Power for Health: The Grassroots Politics of Sustaining and Strengthening Medicaid," *Journal of Health Politics, Policy and Law,* 2025, vol. 50, pp. 189–221; Jamila Michener, "Medicaid and the Policy Feedback Foundations For Universal Healthcare," *The ANNALS of the American Academy of Political and Social Science,* 2019, vol. 685, pp. 116–34.

50. Meredith Melland, "How Milwaukee's Community Organizations Are Responding to Federal Funding Cut," *Wisconsin Watch*, March 27, 2025, https://wisconsinwatch.org/2025/03/milwaukee-federal-funding-cuts-organizations-neighborhood-community-wisconsin/

51. Luke Mayville, "Do Something Big: How Progressives Win in Rural America," *Commonweal*, 2020, vol. 147, pp. 15–18.

can generate symbolic benefits, by contesting the notion that Medicaid spending is wasteful or that it benefits those who are "undeserving" of public support. This battle continues, of course, and contemporary efforts by congressional Republicans to retrench Medicaid spending are premised on just such arguments. Yet to the extent that Medicaid policies can further embed the public belief that health provision has the status of a social "right", retrenchment will remain a political liability.

The best defense of Medicaid, however, is a good offense. And a good offense must contend with both the privatization of Medicaid service delivery via MCOs. Because MCOs' profit-maximizing behavior conflicts beneficiaries' health needs, and because MCOs now possess a unique source of structural power (see above), Medicaid privatization constitutes opportunities for campaigns that expose the tensions between public health goals and private profit.

Organizing against MCO abuses requires developing institutional alternatives that can provide beneficiaries with collective leverage. Beneficiary unions or associations, modeled on successful examples like the Debt Collective, could provide institutional vehicles for collective bargaining with MCOs and state agencies.[52] These organizations could mobilize beneficiaries to demand improved service delivery, reduced administrative burdens, and enhanced beneficiary rights while building the organizational capacity necessary for broader political mobilization. One advantage these organizations might have in launching national campaigns is that the Medicaid MCO market share is consolidated in a small number of large firms.

Connecting Medicaid to the struggle for universal health care

While the campaigns and conflicts described above can be useful for building the political power and resources of Medicaid beneficiaries, it is also important to recognize the inherent limitations of Medicaid as a vehicle for class struggle. At best the program only partially decommodifies basic needs for those it covers. Medicaid's strict eligibility rules, administrative complexity, and growing privatization mean that it cannot fully insulate beneficiaries from market dependency. Moreover, the program's means-tested, decentralized design divides working-class constituencies,

52. Hannah Appel, Sa Whitley, and Caitlin Kline, *The Power of Debt: Identity and Collective Action in the Age of Finance,* UCLA Luskin Institute on Inequality and Democracy, 2019, https://escholarship.org/uc/item/2hc1r7fx.

undermining the potential for broad-based coalitions. Organizing Medicaid beneficiaries must therefore be seen as a means of building a coalition to support universal coverage.

Institutionally, state-level Medicaid expansion has the potential to serve as an incubator for a single-payer program. Canada provides a useful, if partial, analogue here.[53] The Canadian single-payer system began in 1947 in one province, Saskatchewan, but swiftly produced a model that, even in the face of massive opposition from physicians expanded access to care while increasing quality and lowering costs. Within two decades — thanks not only to the positive effects of the program itself but also the mobilization of "labor and farm organizations, consumer groups, community associations and many churches," it was enacted on a national level.[54]

The circumstances are no doubt different in the US at present than they were when Saskatchewan forged the pins and trusses of the Canadian health care system. On the one hand, no state enjoys the leadership of a subnational party like Saskatchewan's Co-operative Commonwealth Federation (which gave birth to the New Democratic Party). Union density is far lower in most US states than in midcentury Saskatchewan. And the flourishing of the private insurance industry has created a kind of organized economic opposition more powerful than the pioneers of Canadian single-payer faced in their day. These are no doubt long odds, but the Trump administration's current war on health coverage should – if nothing else – lay bare the costs of continuing to defend (and incrementally improve) a system that is so obviously politically unsustainable.

Medicaid beneficiaries, along with health care workers, could ostensibly provide an important part of the coalition for a state-based single-payer program, as they would be rolled into coverage along with those currently under employer-sponsored plans, Medicare, and the uninsured. Models for such a program are already well developed. Perhaps the most prominent and politically viable example is the New York Health Act (NYHA), which would create a single-payer system to cover every New Yorker "without deductibles, copays, or restricted provider networks."[55] An independent analysis of the plan by the RAND Corporation finds that

53. Gregory Marchildon, *Tommy Douglas and the Quest for Medicare in Canada,* University of Toronto Press, 2024.

54. Lorne Brown and Doug Taylor, "The Birth of Medicare," *Canadian Dimension*, July 3, 2012, https://canadiandimension.com/articles/view/the-birth-of-medicare

55. Richard N. Gottfried, "Single-payer Plan for New York Could Lead the Country," *American Journal of Public Health*, 2022, vol. 108, pp. 452–53.

it would "expand coverage without substantial increases in overall health care spending."[56]

If the advocates of the NYHA have largely solved the major policy problems, political coordination challenges endure. After being introduced for the first time in 2021, the legislation — despite having support from a majority of state legislators — initially faced opposition from organized labor and insurance companies.[57] By 2023, however, supporters of the legislation had gained powerful labor allies, including the New York State Nurses Association, the Communication Workers of America, and Service Employees International Union. Given their aversion to losing their current insurance arrangements, public sector unions still opposed the legislation, which died in the 2023-24 legislative session. Yet supporters have sought to win them over by emphasizing the limits of their own plan, including limited networks, rising premiums, and the absence of coverage for long-term care. As the ongoing effort illustrates, expanding the conflict will require reconciling labor's internal divisions as much as it will involve mobilizing against the insurance industry itself.[58] Regardless of how these thorny challenges are solved, however, bringing even a small fraction of the state's over 7.5 million Medicaid beneficiaries into the fight would have a political "multiplier effect" rarely seen in American politics.

56. Jodi L. Liu, Chapin White, Sarah A. Nowak, Asa Wilks, Jamie Ryan, Christine Eibner, "An Assessment of the New York Health Act," RAND Corporation, https://ilny.us/images/Documents/Programs/RAND_RR2424.pdf

57. Julia Rock, "New York Democrats Seem to Be Giving Up on State-Level Medicare for All," *Jacobin* June 11, 2021, https://jacobin.com/2021/06/single-payer-health-care-new-york-state-legislation

58. "Gustavo Rivera: 'I Want to Destroy Health Insurance Companies' Business Model'," *Jacobin,* August 3, 2023, https://jacobin.com/2023/08/gustavo-rivera-new-york-state-senate-single-payer-health-care.

Conclusion

Since 1965, Medicaid has grown from a marginal component of the US health care system into one of the dominant sources of insurance for working-class Americans. Yet while the program is expansive, its size and scale do not equate to political power for its beneficiaries. The program's means-tested logic not only creates disruptions in care in the form of "churn," it also politically disorganizes and demobilizes its direct beneficiaries. Present political battles over the program reveal its contradictory nature. While Medicaid has slid into the status of a middle-class entitlement, it is still derided by conservatives as a form of "welfare medicine." While the program has significant economic multiplier effects, it has also allowed for the concentration of structural power on the part of managed-care companies. Finally, while the program is popular, its complex fiscal and administrative arrangements make it difficult for beneficiaries to notice — and hold elected officials accountable for — programmatic changes that worsen access and care quality.

Especially as the Medicaid population undergoes unprecedented cuts — the largest in the program's history, and one of the most significant episodes of social policy retrenchment in the history of the American welfare state — exploiting these contradictions has the potential to catalyze a working-class movement for health equity. Not only will the cuts disenroll millions of Medicaid beneficiaries in every congressional district, but they will also have a devastating effect on rural and urban health hospital systems, whose payrolls hinge on Medicaid reimbursement. Most importantly, the economic ripple effects from these changes have the potential to unite beneficiaries of Medicaid to the struggle of workers in the care sector. Organized workers in a sector that represents over 17 percent of GDP have far greater structural power than any set of policy beneficiaries. A movement that unites the cause of labor to the cause of universal coverage — while not without contradictions to resolve — has the potential to be a formidable political force. In short, whatever form the policy of universal health insurance takes, the numbers suggest that the ***political route*** to this reform runs directly through Medicaid.

Such a movement, it must be stressed, will not emerge on its own. Coverage losses tend to have a demobilizing effect on Medicaid

beneficiaries. Moreover, when rural hospitals close, voters who experience these losses become increasingly likely to support Republicans who supported the policies that produced the closure.[59] On the one hand, this reflects the diffuse nature of accountability in the Medicaid program. At the same time, it illustrates that the powerful role of partisan identification in structuring how voters ascribe credit and blame. If anything, these findings suggest that if political parties and movement organizations do not harness the unfolding coverage losses to build political power, the opportunity may soon slip away.

59. Michael E. Shepherd, "The Politics of Rural Hospital Closures," *Political Behavior,* February 2025, vol. 47, pp. 1–47.

Medicaid and the Struggle for Universal Health Care in the Trump Aftermath

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Publication design by Sophie Monk

Data visualisations by Pinelopi Gardika

November 2025

The author would like to thank Melanie Brusseler and George Macbeth for their editorial assistance.

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