Introduction: Medicaid at 60

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Medicaid was established 60 years ago through the Social Security Amendments of 1965. When President Lyndon B. Johnson signed the landmark law on July 30, 1965, at the Truman Presidential Library, Medicare received virtually all the attention. Indeed, the *New York Times* front-page article on the signing ceremony gave Medicaid no mention (Morris 1965). Medicare's enactment represented the culmination of a decades-long struggle to provide federal health insurance through the Social Security system (Oberlander 2003). Like Social Security, Medicare is a national social insurance program in which workers earn rights to future benefits through payroll tax contributions. In contrast, Medicaid was created as a means-tested, state-administered program for poor people who met certain categorical requirements, such as having dependent children. Liberal health reformers viewed Medicaid as merely a gap-filling program, and many hoped it would be superseded. They were confident that Medicare would build momentum for a system of universal coverage, and they expected Medicaid to be eliminated when a national health insurance program was adopted (Grogan 2013).

But US health policy making took a different path. While "Medicare for All" remains the "road not taken" (Oberlander and Marmor 2015: 55), Medicaid has not just endured but also has experienced dramatic growth over the past six decades. During the 1980s and 1990s, Congress adopted a series of incremental Medicaid expansions for pregnant women, infants, the elderly, and the disabled (Grogan and Patashnik 2003). Because of the prohibitive cost of long-term care, millions of nursing home residents who

were ineligible for Medicaid at the time of their admission enroll in the program after having spent down their assets (Grogan 2013). As a result of these developments, "Medicaid has been transformed from a program for the very poor into a benefit that reaches into the middle class," even though Medicaid has never fully escaped its "poor law legacy" (Quadagno 2015: 83). In another important milestone, the Affordable Care Act used Medicaid, not Medicare, as the programmatic vehicle for coverage expansion. While the US Supreme Court's 2012 ruling in *Federation of Independent Business (NFIB) v. Sebelius* made the Medicaid expansion optional for states, 40 states and the District of Columbia are participating as of August 2024.

Today Medicaid is America's largest source of health insurance coverage—and the nation's most important program for combating health disparities. In June 2024, Medicaid covered 73 million people, or around one in five Americans (CMS 2024). While the number of Medicaid enrollees has declined from its COVID-era peak as a result of the unwinding of the continuous enrollment provision, the program will continue to provide critical support to many vulnerable populations. In recent years, Medicaid has covered about four in 10 children, more than four in 10 nonelderly people with disabilities, and about six in 10 adults living below the poverty line (Rudowitz et al. 2024). Medicaid is associated with positive outcomes, including improved access to care, better self-reported health, an increase in the treatment of chronic conditions and substance use disorders, and greater financial security for low-income families (CEA 2021). There is causal evidence that Medicaid reduces mortality rates. According to one study, the Medicaid expansion under the Affordable Care Act saved the lives of at least 19,200 low-income adults aged 55 to 64 between 2014 and 2017 alone (Miller, Johnson, and Wherry 2021).

Medicaid's 60th anniversary presents an opportunity to take stock of the program's past, present, and future possibilities. This special issue brings together leading scholars from varied disciplinary perspectives to consider several issues, including Medicaid's impact on health disparities, its role in addressing the social determinants of health, and the program's consequences for the political attitudes and civic engagement of both Medicaid enrollees and the general public.

The first four articles in this special issue focus on the politics of Medicaid. In "Medicaid's Political Development since 1965: How a Fragmented and Unequal Program Has Expanded," Colleen Grogan explores the tensions at the heart of the Medicaid program today. On the one hand, Medicaid is unlikely to ever return to its origins as "welfare medicine."

Medicaid's enormous spending has generated vested interests in an enlarged program among state governments, hospitals, nursing homes, and millions of American families who rely on the program. On the other hand, Grogan argues that Medicaid remains a fragmented and highly unequal program. Medicaid is still vulnerable to retrenchment politics, and partisan debates continue to flare over the deservingness of some of its constituency groups.

In the second article, "Policy Feedbacks and Medicaid on its 60th Anniversary," Andrea Campbell analyzes Medicaid not as the outcome of the political process but as an input into it, exploring how Medicaid's own dynamics shape public opinion, political participation, interest group support, and other factors that influence the program's growth and durability. Overall, Campbell finds that Medicaid has produced only modest, short-term increases in the political participation of low-income beneficiaries. However, the program's relevance to some higher-participation groups such as the middle class and rural populations has generated a protective coalition possessing the capacity to defend Medicaid against threats and provide cover to conservative politicians voting for Medicaid expansions.

In "Building Power for Health: The Grassroots Politics of Sustaining and Strengthening Medicaid," Jamila Michener examines the role of grassroots political organizing in sustaining and strengthening Medicaid. Drawing on in-depth interviews with the leaders of organizing and advocacy groups across the United States, she produces new insights into how these bottom-up actors are engaging in Medicaid politics, the approaches they are using to strategically advance their collective interests, and the barriers they perceive to achieving greater power among the communities and groups most directly affected by Medicaid policy.

In "Rationing Rights: Administrative Burden in Medicaid Long-Term Care Programs," Pamela Herd and Rebecca Johnson examine a largely hidden dimension of Medicaid politics: the use of opaque, time-intensive bureaucratic procedures (such as lengthy applications and confusing eligibility rules) to limit disabled persons' access to Medicaid home and community-based services. The authors uncover evidence that states strategically deploy administrative burdens to conceal rationing and manage the tension between controlling costs and protecting the right of disabled people to live in the community. Their analysis suggests that policy makers and advocates should give much greater attention to how administrative burdens generate inequality and undermine transparency. These burdens not only make it more difficult for vulnerable constituents to access needed benefits; they also make it more challenging for citizens to hold elected

officials accountable for waiting lists and the procedures for deciding who comes off of them to receive services.

The next two articles provide detailed examinations of the coverage of racial and ethnic minorities and immigrants under Medicaid and related programs. In their article "Closing Gaps or Holding Steady? The Affordable Care Act, Medicaid Expansion, and Racial Disparities in Coverage, 2010–2021," Benjamin Sommers, Rebecca Smith, and Jose Figueroa leverage nationally representative data to measure absolute and relative changes in the uninsured rate during 2010–2021 across and between racial and ethnic groups. They find that the Affordable Care Act reduced uninsurance rates for all such groups in the United States, but the patterns of changes in disparities varied by group, state Medicaid expansion status, and whether the focus is on absolute or relative differences in coverage levels. Taken together, the article's findings suggest the need for additional interventions to reduce remaining disparities and boost coverage rates among minority groups.

In "Public Health Insurance Coverage for Immigrants during Pregnancy, Childhood, and Adulthood: A Discussion of Relevant Policies and Evidence," Laura Wherry, Rachel Fabi, and Maria Steenland investigate the eligibility of low-income immigrants for Medicaid and the Children's Health Insurance Program under a complicated patchwork of federal and state policies. They provide detailed information on how eligibility for publicly funded insurance coverage varies across immigrant population groups, including citizens, noncitizens who are lawfully present, and undocumented persons such as Deferred Action for Childhood Arrivals recipients. The article also presents a systematic literature review on what is known about the impact of expanded public insurance for immigrants' coverage, health care utilization, and health outcomes.

An important recent development in Medicaid policy making is the growing use of Medicaid to target the social determinants of health. Many Medicaid recipients have unmet social needs, such as a lack of access to affordable housing and adequate food. Unmet social needs can have a determinantal effect on Medicaid enrollees' health, such as by making it harder for people with a chronic illness to attend medical appointments or store medication (Orris, Bailey, and Sullivan 2024). Recognizing the linkage between unmet social needs and health, the federal government has given states new flexibility to use Medicaid waivers to provide food assistance and housing support (Orris, Bailey, and Sullivan 2024).

In the final article in this special issue, "Entrenched Opportunity: Medicaid, Health Systems, and Solutions to Homelessness," Charley Willison, Naquia Unwala, and Katarzyna Klasa examine the investments of Medicaid

programs and major hospital systems in solutions to homelessness. The study finds that nearly one third of states are using Medicaid waivers to address homelessness, and more than half of the 100 largest health systems in the United States have homelessness mitigation policies. The article identifies coordination challenges that arise as Medicaid and health systems seek to address homelessness. Finally, the authors recognize that the greater involvement of Medicaid and health systems in homelessness policy has important implications for governance and power, and they caution that it is important to ensure that homelessness policy expertise is not lost as Medicaid and health system actors become more prominent players in this issue space.

Taken together, the articles in this special issue describe the evolution of the Medicaid program over the past 60 years. They present a deep understanding of the program's growth as well as the program's inherited political strengths and vulnerabilities. With Donald Trump returning to the White House and Republican majorities in both the House and the Senate, Medicaid's resilience will be tested. Significant changes in the program—including work requirements and cuts in eligibility, benefits, and provider payments—may be on the agenda. The articles in this special issue provide context to help citizens, advocates, and policy makers understand debates over Medicaid's design and funding—and offer insights into the program's social role and impact on vulnerable communities.

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