

THE NEXT CHAPTER IN HEALTH CARE FEDERALISM: EXPANDING MEDICAID FROM THE GROUND UP

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In much of the South and a few other conservative states, 1.4 million low-income adults have been excluded from access to Medicaid coverage. Now, in the wake of federal lawmaking in 2025, millions of additional Americans nationwide (including in these states) will lose access to Medicaid benefits and affordable health insurance. With America’s population of uninsured and underinsured people poised to grow dramatically, this might seem like a foolish time to talk about Medicaid expansion.

But new pressures can generate new politics. This Essay focuses on states that have opted out of Medicaid expansion, where a rising tide of newly uninsured people may nudge those states to seek new and politically low-profile ways to make up for lost ground. This Essay argues that local governments—particularly, multicounty partnerships brokered with these states’ biggest central hospital complexes—should be the focus of a new phase of policy development for low-income health care. Just as local governments were at the vanguard of Medicaid expansion in early Affordable Care Act implementation, they can become important leaders in a new wave of lawmaking to, at long last, bring health care access to low-income communities in the South and Midwest.

Introduction	1224
I. Medicaid Expansion Before and After the One Big Beautiful	
Bill Act	1231
A. Medicaid Expansion Before the Summer of 2025	1232
B. The New Status Quo	1235

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II.	The Historical Context of a Federal-Local Alternative	1237
A.	The “ACA’s Federalism”	1237
B.	The Federal-Local Roots of the ACA: Section 1115 Waivers	1239
III.	Policy Models	1241
A.	Statutory Medicaid-Based Approaches	1242
B.	ACA Marketplace Solutions	1244
C.	Enhanced Grantmaking	1247
D.	Section 1115 Waivers	1248
IV.	Politics and Open Questions	1249
	Conclusion	1252

INTRODUCTION

The major complex of seven hospitals and ancillary health facilities in Jackson, Mississippi, is a busy, important place. From across a wide region, it is where you go, if you can, to give birth, undergo heart surgery, replace a painful hip, or treat military post-traumatic stress disorder. In a medical emergency, an ambulance or helicopter will bring you to the state’s only Level I trauma center.¹ Every year, 900 or so babies begin their lives in the state’s most advanced neonatal intensive care unit.² A major cancer center supports more than 2,000 children and adults annually through frightening and immiserating months of cancer treatment.³ The University of Mississippi Medical Center trains the next generation of nurses, doctors, and biomedical researchers.

Early each morning, a stream of people in scrubs arrive at this complex to take care of other people. More than 19,200 people work here.⁴ New shifts arrive throughout each day, staffing wards and a giant emergency room 24/7. Pedestrians are rare in the wider, struggling city

1. See MISS. STATE DEP’T OF HEALTH: TRAUMA SYS. OF CARE, MISSISSIPPI TRAUMA CARE SYSTEM DESIGNATED AND UNDESIGNATED HOSPITAL (90 DESIGNATED TRAUMA CENTERS) 1 (2025), <https://msdh.ms.gov/page/resources/2739.pdf> [<https://perma.cc/D2Q9-C3SE>].

2. *Newborn/Neonatal Intensive Care Unit (NICU)*, CHILD.’S OF MISS., <https://umc.edu/Childrens/Neonatology/NICU.html> [<https://perma.cc/UPE9-RVAW>] (last visited Oct. 4, 2025).

3. See *Cancer Center and Research Institute*, UNIV. OF MISS. MED. CTR., <https://umc.edu/cancerinstitute/Home-Page.html> [<https://perma.cc/YKG3-73QQ>] (last visited Oct. 4, 2025); *Cancer*, UMMC HEALTH CARE, https://umc.edu/Healthcare/Cancer/Cancer_Home.html [<https://perma.cc/GPB2-RTG4>] (last visited Oct. 4, 2025).

4. Data on file with authors, based on *Largest Employers*, CAREERONESTOP, <https://www.careeronestop.org/Toolkit/Jobs/find-largest-employers.aspx?&location=MS&pagesize=50&curpage=1> [<https://perma.cc/9TTJ-CU28>] (last visited Nov. 23, 2025) (totaling employee counts from all Jackson-based health care employers ranked in the state of Mississippi’s top 150 largest employers).

of Jackson, but the sidewalks crossing this complex are more like what you would expect in a typical state capital. Many of the city's remaining restaurants are on these blocks too, serving everything from lunchtime chicken wings to a steak dinner with a whiskey flight. In a state that has been fighting against the loss of college-educated people for decades,⁵ this is a place where Mississippi-born health care professionals can make a life close to extended family.

This central health care hub is not just important to patients, to providers, and to the Jackson Metro Area. It is also important to the entire state of Mississippi. The complex includes three of the twelve largest employers in the state among all industries.⁶ Health care's share of total employment in Mississippi is greater than that ratio in forty-seven other U.S. states.⁷ The state's economic development authority promises that health care in Mississippi is "[a] thriving industry built on history, innovation and talent."⁸

The state's economic future relies on its ability to retain and grow the health care workforce, which, in turn, ensures that the state's broader workforce is healthy. Yet across generations and demographics, a significant share of Mississippians cannot afford to pay for health insurance out of pocket. In fact, in 2023 (the latest available year of data processed comparatively across states), 18 percent of Mississippians lived below the poverty line and nearly 6 percent were living "near poverty"—figures that represent America's second highest state poverty rate and highest rate of people defined as "nearly poor."⁹ An intergenerational black–white wealth gap, which is rooted in one of the nation's most violent histories of enslavement and racial discrimination,

5. Jake McGraw, *FAQ: The Mississippi 'Brain Drain' Crisis*, MISS. TODAY (July 15, 2025), <https://mississippitoday.org/2025/07/15/faq-mississippi-brain-drain-crisis/>.

6. These are the University of Mississippi Medical Center, Baptist Health Systems, and St. Dominic Memorial Hospital. *Largest Employers*, *supra* note 4.

7. See *Occupational Employment and Wages, May 2023*, U.S. BUREAU OF LAB. STAT. (Apr. 3, 2024), <https://www.bls.gov/oes/2023/may/oes290000.htm> [<https://perma.cc/Z6ZF-FPP3>] (ranking the states with the highest concentration of jobs and location quotients in the industry sector titled "Healthcare Practitioners and Technical Occupations" and placing Mississippi in third place with 84,280 jobs, a rate of 73.29 jobs per 1,000 in any sector); see also *May 2023 State Occupational Employment and Wage Estimates*, U.S. BUREAU OF LAB. STAT. (Apr. 3, 2024), https://www.bls.gov/oes/2023/may/oes_ms.htm [<https://perma.cc/6ZYY-GQM2>] (posting the original data).

8. *Living in Mississippi*, MISS. DEV. AUTH., <https://mississippi.org/doing-business/live/> [<https://perma.cc/3XWM-TRNJ>] (last visited Oct. 30, 2025).

9. See CRAIG BENSON, U.S. CENSUS BUREAU, ACSBR-022, POVERTY IN STATES AND METROPOLITAN AREAS: 2023, at 3, 7–8 (2024), <https://www2.census.gov/library/publications/2024/demo/acsbr-022.pdf> [<https://perma.cc/4SE4-DVP4>] (based on figures in Table 1 and Appendix Table 1).

affects all ages and locations in the state.¹⁰ The state has no minimum wage above the federal floor of \$7.25 per hour¹¹ and offers among the weakest safety nets in any state.¹²

A major hospital complex like Jackson's relies on government research grants, private philanthropy, and partnerships with medical training programs.¹³ But its core revenues come from delivering care.¹⁴ People need health care; they pay for that care through insurance coverage. Those coverage systems include Medicare, of course, which funds health care for more than 640,000 elderly and disabled Mississippians.¹⁵ They also include Medicaid, which funds care for

10. See *III.B. Overview of the State - Mississippi - 2021*, U.S. DEP'T OF HEALTH & HUM. SERVS.: HRSA MATERNAL & CHILD HEALTH, <https://mchb.tvisdata.hrsa.gov/Narratives/Overview/9a62acf8-1ab6-4e9a-b92f-9037110117e7> [<https://perma.cc/84Q8-2XNG>] (last visited Oct. 30, 2025); see also *Why Mississippi Can't Wait for Economic Justice*, SPLC (July 15, 2025), <https://www.splcenter.org/resources/reports/why-mississippi-cant-wait-economic-justice> [<https://perma.cc/SJ7J-X3RF>] (reporting higher levels of poverty among black Mississippians compared to white residents); Byron D'Andra Orey, *White Unearned Advantage: How DEI Challenges Comfortable Ignorance*, MISS. TODAY (Mar. 7, 2025), <https://mississippitoday.org/2025/03/07/dei-challenges-comfortable-ignorance/> (noting "how slavery, segregation and systemic disinvestment created today's racial wealth gap").

11. *State Minimum Wage Laws*, U.S. DEP'T OF LAB.: WAGE & HOUR DIV. (July 31, 2025), <https://www.dol.gov/agencies/whd/minimum-wage/state> [<https://perma.cc/S3TY-4B8Y>].

12. See Gabriela Goodman & Tara Watson, *How Generous Are Each State's Safety Net Programs?*, BROOKINGS INST. (Nov. 28, 2023), <https://www.brookings.edu/articles/how-generous-are-each-states-safety-net-programs/> [<https://perma.cc/D883-PBTM>] (listing Mississippi as one of the states offering the fewest safety net benefits for single-parent families, including the lowest expenditures under the Temporary Assistance for Needy Families program).

13. See generally Yoku Shaw-Taylor, *Nongovernment Philanthropic Spending on Public Health in the United States*, 106 AM. J. PUB. HEALTH 58 (2016) (analyzing health expenditure data to determine "the dollar amount of nongovernment philanthropic spending on public health activities in the United States"); Juliette Cubanski, Alice Burns & Cynthia Cox, *What Does the Federal Government Spend on Health Care?*, KFF (Feb. 24, 2025), <https://www.kff.org/medicaid/what-does-the-federal-government-spend-on-health-care/> [<https://perma.cc/5SGY-VA7E>] (noting that federal health care spending, totaling \$1.9 trillion, provides major support for programs including medicare and Medicaid).

14. See Zachary Levinson, Scott Hulver, Jamie Godwin & Tricia Neuman, *Key Facts About Hospitals*, KFF (Feb. 19, 2025), <https://www.kff.org/health-costs/key-facts-about-hospitals/?entry=national-hospital-spending-spending-by-payer> [<https://perma.cc/G9N8-2VND>] (documenting that private health insurance, Medicare, Medicaid payments, and out-of-pocket patient care accounted for a total of 84 percent of the spending on hospital care in 2023).

15. *Total Number of Medicare Beneficiaries by Type of Coverage 2024*, KFF, <https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/> [<https://perma.cc/N7F3-PC6Z>] (last visited Oct. 4, 2025).

approximately 667,000 children, pregnant and disabled people, and elderly patients in the state.¹⁶

In Jackson (as in comparable hospital complexes scattered across the South and Midwest), other low-income adults could be, but are not, able to access health care through Medicaid. That fact dates back to the U.S. Supreme Court decision in *National Federation of Independent Business v. Sebelius*,¹⁷ which forced the modification of the Patient Protection and Affordable Care Act of 2010 (ACA) to allow states to opt in or opt out of the ACA's Medicaid insurance expansion.¹⁸ This now-optional expansion allows low-income adults earning up to 138 percent of the federal poverty line (which, in 2025, meant an individual could earn up to \$21,597) to qualify for Medicaid coverage.¹⁹

The ten states (including Mississippi) that continue to refuse this federally subsidized expansion of Medicaid have created a so-called "coverage gap" for people who earn more than their state's Medicaid eligibility threshold but too little to qualify for tax credits that would help them afford insurance in the ACA Marketplace.²⁰ In 2025 in Mississippi, 70,000 adults fell into that coverage gap.²¹ Across all opt-out states, 1.4 million low-income people are excluded from coverage in this way.²²

Federal laws passed in the summer of 2025 will further increase the uninsured or underinsured population in both opt-in and opt-out states. The 2025 federal budget reconciliation law (titled the "One Big Beautiful Bill Act" (OBBBA))²³ cut funding for and further restricted Medicaid and ACA coverage.²⁴ Together, these reforms are expected to increase the

16. *Medicaid in Mississippi*, KFF (May 2025), <https://files.kff.org/attachment/fact-sheet-medicaid-state-MS> [<https://perma.cc/7T7P-A48N>].

17. 567 U.S. 519 (2012).

18. *Id.* at 588.

19. *Status of State Medicaid Expansion Decisions*, KFF (Sep. 29, 2025), <https://www.kff.org/medicaid/status-of-state-medicaid-expansion-decisions/> [<https://perma.cc/RB9M-DXX7>].

20. Sammy Cervantes, Clea Bell, Jennifer Tolbert & Anthony Damico, *How Many Uninsured Are in the Coverage Gap and How Many Could be Eligible if All States Adopted the Medicaid Expansion?*, KFF (Feb. 25, 2025), <https://www.kff.org/medicaid/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/> [<https://perma.cc/N5Q3-ZXKB>].

21. *Medicaid in Mississippi*, *supra* note 16; see also *The Medicaid Coverage Gap in Mississippi*, CTR. ON BUDGET & POL'Y PRIORITIES (Apr. 3, 2024), <https://www.cbpp.org/sites/default/files/4-3-24health-factsheet-ms.pdf> (finding a coverage gap of 81,000 people using 2022 data).

22. Cervantes, Bell, Tolbert & Damico, *supra* note 20.

23. This Essay will primarily refer to the summer 2025 federal budget reconciliation law—H.R. 1, One Big Beautiful Bill Act—as the OBBBA.

24. One Big Beautiful Bill Act, Pub. L. No. 119-21, §§ 71101-71401, 139 Stat. 72, 290-327 (2025).

number of uninsured people by 10 million by 2034.²⁵ It is no accident that millions of people will lose health care coverage under the new system: Those losses were designed to generate federal savings to offset the OBBA's tax cuts.²⁶ When combined with the expected expiration of Marketplace-enhanced premium tax credits (the fight at the heart of the October 2025 government shutdown²⁷), that number rises to more than fourteen million.²⁸

In the wake of the reconciliation law, by 2034, the number of uninsured people in Mississippi alone is expected to climb by 37,000.²⁹ Even now, before the health care cuts go into effect, Mississippi has the sixth-highest rate of uninsured people among U.S. states, with more than one in ten residents lacking any kind of health insurance.³⁰ Hospital complexes like the one in Jackson already care for uninsured people in their emergency rooms, providing uncompensated care or escalating unpayable medical debt. The fiscal impacts of the 2025 changes are expected to be especially devastating for hospitals in opt-out states that serve high numbers of lower-income patients who afford care through Medicaid or ACA subsidies.³¹

For years, advocates who care about low-income people's access to health care in opt-out states—including those focused broadly on chronic poverty in the South—lobbied those states to make a federal deal for

25. Alice Burns, Jared Ortaliza, Justin Lo, Matthew Rae & Cynthia Cox, *How Will the 2025 Reconciliation Law Affect the Uninsured Rate in Each State?*, KFF (Aug. 20, 2025), <https://www.kff.org/uninsured/how-will-the-2025-reconciliation-law-affect-the-uninsured-rate-in-each-state/> [https://perma.cc/S2U3-3XVW].

26. See Rhiannon Euhus, Elizabeth Williams, Alice Burns & Robin Rudowitz, *Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package*, KFF (July 23, 2025), <https://www.kff.org/medicaid/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-enacted-reconciliation-package/> [https://perma.cc/AF9W-GF9E].

27. Sarah D. Wire, *Democrats Want Health Care Tax Credits to End the Shutdown. Why the GOP Says Not Yet.*, USA TODAY (Oct. 9, 2025, at 15:30 ET), <https://www.usatoday.com/story/news/politics/2025/10/08/obamacare-tax-credits-matter-government-shutdown/86418852007/> [https://perma.cc/SMF5-RQGY].

28. Burns, Ortaliza, Lo, Rae & Cox, *supra* note 25.

29. *Id.*

30. *Health Insurance Coverage of the Total Population*, KFF, <https://www.kff.org/state-health-policy-data/state-indicator/total-population/> [https://perma.cc/4LZ8-C5HF] (last visited Oct. 4, 2025); *Mississippi*, GEO. UNIV.: CTR. ON HEALTH INS. REFORMS, <https://healthjournalism.org/wp-content/uploads/2025/01/Mississippi-for-AHCJ2024.pdf> [https://perma.cc/GV38-7EUH] (last visited Oct. 4, 2025).

31. See Zachary Levinson, Tricia Neuman & Jamie Godwin, *What Are the Implications of the 2025 Budget Reconciliation Bill for Hospitals?*, KFF (June 12, 2025), <https://www.kff.org/medicaid/what-are-the-implications-of-the-2025-budget-reconciliation-bill-for-hospitals/> [https://perma.cc/A8SB-L4YZ].

Medicaid expansion.³² For the sake of low-income people in rural areas and smaller cities, that path remains the best option. But the 2025 reality of health care politics means that any option to bring down the number of uninsured people should be on the table.

This Essay argues that the next generation of health care advocacy in opt-out states should explore a new path: to look beyond states as the federal government's exclusive partners by recognizing the role that cities and counties have played and could play. Multicounty partnerships in the biggest metro areas of the opt-out states would reach significant shares of each opt-out state's coverage-gap population. Such partnerships would also reinforce the fiscal solvency of the major health care complexes located in those metros' central cities like Jackson. Critical medical complexes in opt-out states are concentrated in cities such as Birmingham, Alabama; Miami, Florida; Greenville, South Carolina; Nashville and Memphis, Tennessee; Houston and San Antonio, Texas; Madison, Wisconsin; and Casper, Wyoming.³³

Readers familiar with health care policy will immediately see that a county-based approach to expanding coverage is a lesser alternative to a national or state-based one. In an already fragmented landscape, further fragmentation is burdensome and costly. A local approach will also favor residents of the biggest urban metro areas, leaving the coverage gap intact elsewhere. And local governments (especially those in opt-out states) lack the major administrative agencies needed to administer health care coverage—the complexities of which states have spent decades navigating and refining.

We agree with all of these concerns. Challenges, both legal and political, abound on a locally focused path. While every proposal described in this Essay is thus a second-rate alternative to statewide expansion, the hardened opposition to expansion in the remaining opt-

32. See, e.g., Drew Hawkins, *Here's What's Holding Back Medicaid Expansion in Mississippi and Other Southern States*, NPR (May 16, 2024, at 10:53 ET), <https://www.npr.org/sections/health-shots/2024/05/16/1251691921/medicaid-expansion-mississippi-alabama-south> [<https://perma.cc/RJ8L-VP6J>] (describing “the ‘drumbeat’ of support” for Medicaid expansion among a range of health care industry and public interest actors); Bryce Ward, *The Impact of Medicaid Expansion on States' Budgets*, COMMONWEALTH FUND (May 5, 2020), <https://www.commonwealthfund.org/publications/issue-briefs/2020/may/impact-medicaid-expansion-states-budgets> (quantifying the fiscal benefits of statewide Medicaid expansion and arguing that states' matching share was, in some cases, fully paid for by the states' reduced health care costs overall).

33. Data on file with authors. See, e.g., *Top Hospitals in Alabama by Net Patient Revenue*, DEFINITIVE HEALTHCARE (Apr. 17, 2024), <https://www.definitivehc.com/resources/healthcare-insights/top-hospitals-alabama-net-patient-revenue> [<https://perma.cc/7U7W-TVW7>]; Chris Erickson, *Largest Hospitals in Florida*, TAMPA BAY BUS. J. (Oct. 27, 2025, at 13:20 ET), <https://www.bizjournals.com/tampabay/subscriber-only/2025/01/03/largest-hospitals-in-florida.html>.

out states and the anti-Medicaid politics of current federal Republicans make “second-rate alternatives” look more like “not giving up.” In any event, the dramatic cuts of 2025 call for new, experimental ideas.

This Essay gathers and juxtaposes several models for locally led and locally administered expansion of health care coverage. Our goal is not to develop these approaches in technical or legal terms. Instead, we aim to present an aerial view of pathways worth future exploration and conversation. Part I summarizes the key factual background, including the basics of Medicaid expansion and the OBBBA’s impact on that sphere. Part II captures the historical and theoretical context of federalism in health care in the post-ACA period, including the locally led precedent for the ACA itself. We present four contemporary models for locally led health care expansion for low-income people in Part III. In Part IV and in a brief conclusion, we preview the implications and open questions for this path.

The audience of these proposals is varied. We are writing for people such as: moderate Republican and Democratic lawmakers in states that have thus far opted out of Medicaid expansion, Republican majorities in Congress facing pressure to shield the health care industry in conservative opt-out states from fiscal losses, federal Democratic leaders nationwide who find themselves seeking new angles of approach after a massive regression in health care access, hospital administrators and other health sector players struggling to find solutions to ongoing and incoming budget shortfalls, health care policy experts and philanthropic foundations in a position to design and fund local experiments, and patient and coverage advocates seeking new ways to fight their longstanding battle to secure health care access for low-income people. Last and far from least, we are writing to local leaders—whether in government, philanthropy, or the health care sector—who wish to unite partners around an ambitious policy objective of urgent local importance. Local leadership has always been critical to the politics of Medicaid expansion in opt-out states,³⁴ and it may be time for those officials to start

34. See, e.g., Clarissa Donnelly-DeRoven, *Six Republican Counties in WNC Pledged Their Support for Medicaid Expansion. What’s Changed?*, N.C. HEALTH NEWS (Oct. 11, 2021), <https://www.northcarolinahealthnews.org/2021/10/11/six-republican-counties-support-medicaid-expansion-whats-changed> [https://perma.cc/GA4H-UAA8] (illustrating the bipartisan efforts of local commissioners in their ultimately successful Medicaid expansion campaign in North Carolina); Kayla Lewis, *Alachua County Labor Coalition Kicks Off Statewide Medicaid Expansion Initiative*, WCJB (Feb. 3, 2024, at 19:01 CT), <https://www.wcjb.com/2024/02/04/alachua-county-labor-coalition-kicks-off-statewide-medicaid-expansion-initiative/> [https://perma.cc/7FLP-5F9W] (highlighting the presence of Gainesville’s mayor at a campaign to put Medicaid expansion on the ballot in Florida); Morgan McCarthy, *Dunn County Supervisors Support Expanded Medicaid*, *Crisis Support*, 715 NEWSROOM (Oct. 29, 2024), <https://715newsroom.com/2024/10/29/dunn-county-supervisors-support-expanded->

lobbying for something less politically conspicuous than statewide expansion. Such actors may have nothing more in common—and they may need nothing more in common—than a shared interest in mitigating the coverage losses from the OBBBA in a way that can avoid rerunning our highly polarized Medicaid expansion debate.

I. MEDICAID EXPANSION BEFORE AND AFTER THE ONE BIG BEAUTIFUL BILL ACT

Since the Great Recession, several federal safety net programs have been designed (or forced by courts) to give states the power to opt out of the program entirely, even as these programs fell short of the need generated by recessionary shocks.³⁵ These program structures have endured even where local governments in opt-out states have vociferously advocated for access to the federal program.³⁶ But when it comes to the ACA and Medicaid, a story of adaptation—including federal-state compromises to loosen federal Medicaid expansion standards—has shrunk the number of states blocking their citizens from accessing the federal safety net. This Part briefly describes

medicaid-crisis-support [<https://perma.cc/KRB9-M8AN>] (reporting on the passage of county resolutions calling on the state to expand Medicaid in Wisconsin); Dave Williams, *Reed Urges Medicaid Expansion in Georgia*, ATLANTA BUS. CHRON. (Nov. 15, 2013, at 00:00 ET), https://www.bizjournals.com/atlanta/blog/capitol_vision/2013/11/reed-urges-medicaid-expansion-in-georgia.html (covering the Atlanta mayor's call for Medicaid expansion in Georgia).

35. See generally Robert A. Moffitt, *The Great Recession and the Social Safety Net*, 650 ANNALS AM. ACAD. POL. & SOC. SCI. 143 (2013) (documenting expansion of the social safety net during the Great Recession as demonstrated in aggregate per capita expenditures, especially from the Supplemental Nutrition Assistance Program (SNAP) benefits, the Earned Income Tax Credit (EITC), unemployment insurance, and Medicaid programs). See also Robert A. Moffitt & James P. Ziliak, *COVID-19 and the US Safety Net*, 41 FISCAL STUD. 515, 518–23, 534–43 (2020) (documenting increased support from unemployment insurance and food assistance in response to the employment shock of the COVID-19 pandemic); Eric Hembre, Robert A. Moffitt & James P. Ziliak, *Is This Time Different? The Safety Net Response to the Pandemic Recession* 5–11, 17–30 (July 19, 2024) (unpublished manuscript) (on file with Wisconsin Law Review) (comparing the responsiveness of the safety net to the Great Recession and the COVID-19 recession and finding that Unemployment Insurance and SNAP benefits were better adapted to recessionary conditions in the second period).

36. See, e.g., Ashlyn Brothers, *New Orleans Leaders Ask Gov. Landry to Reconsider His Rejection of Summer EBT Program*, Fox 8 (Feb. 14, 2024, at 23:01 CT), <https://www.fox8live.com/2024/02/15/new-orleans-leaders-ask-gov-landry-reconsider-his-rejection-summer-ebt-program/> [<https://perma.cc/M5A4-RUR5>] (covering New Orleans local officials advocating for the state to opt in to USDA food assistance for low-income families with school-aged children over the summer); Drew Hawkins, *'Stupidity of Politics': Medicaid Expansion Effort Dies in Mississippi*, MISS. PUB. BROAD. (May 7, 2024), <https://www.mpbonline.org/blogs/news/stupidity-of-politics-medicaid-expansion-effort-dies-in-mississippi/> [<https://perma.cc/E3ZK-3Z6L>] (describing a major rally and political advocacy for Medicaid expansion).

that history of the ACA's Medicaid expansion and then provides an update as to where 2025 lawmaking leaves that program today.

A. Medicaid Expansion Before the Summer of 2025

The drafters of the ACA did not tackle the issue of local governments that might want to opt in to Medicaid expansion but that were located in a state that had opted out. Under the original Medicaid expansion program passed as part of the ACA in 2010, that scenario was impossible. Congress required every state to adopt Medicaid expansion—a historic expansion of health care coverage that extended Medicaid to adults with incomes up to 138 percent of the federal poverty level³⁷—or risk losing all of their federal Medicaid dollars.³⁸ But the Supreme Court in *Sebelius* held that this penalty was akin to a “gun to the head” and was a violation of the Spending Clause in the U.S. Constitution (Article I).³⁹ The Court ultimately struck down the expansion requirement and left the choice of whether to accept Medicaid expansion up to the states.⁴⁰

For the next decade, supporters of the ACA turned their focus to both its implementation and a hard-fought campaign to bring more states onboard. One by one, states filtered into the program—some by legislation, some by executive action, and yet others by ballot measure.⁴¹ Twenty-six states and the District of Columbia had adopted Medicaid expansion by 2014, and fourteen more states followed over the next decade.⁴² Occasionally, drawing another state into expansion involved

37. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), (e)(14).

38. *Id.* § 1396c.

39. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 581, 575–85 (2012).

40. *Id.* at 588.

41. States expanded Medicaid in what scholars Abbe Gluck and Nicole Huberfeld characterized as four waves of negotiations with the federal government: (1) a first wave of early implementers who acted in 2012, even before the ACA's 2014 start date; (2) a second wave enacted shortly after *Sebelius* upheld the legality of the ACA; (3) a third wave that used demonstration projects, waivers, and U.S. Department of Health and Human Services concessions to tailor the ACA to state politics; and (4) a fourth, more gradual wave after 2014, enacted as states sought to renegotiate their expansion according to the new models emerging across the country. Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Healthcare For?*, 70 STAN. L. REV. 1689, 1734–43 (2018).

42. Jessica Mathers, Jennifer Tolbert, Priya Chidambaram & Sammy Cervantes, *5 Key Facts About Medicaid Expansion*, KFF (Apr. 25, 2025), <https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-expansion/> [https://perma.cc/N6LH-HKGT]. The most recent states to adopt Medicaid expansion in 2023, South Dakota and North Carolina, did so via ballot measure and legislation, respectively. *Id.*; Jada Raphael & Robin Rudowitz, *An Update on ACA Medicaid Expansion: What to Watch in North Carolina and Beyond*, KFF (Dec. 18, 2023), <https://www.kff.org/affordable-care-act/an-update-on-aca-medicaid-expansion-what-to-watch-in-north-carolina-and-beyond/> [https://perma.cc/7EHS-52H7].

compromises on the part of the Obama administration, allowing states to operate Medicaid expansion in ways that deviated from the standard federal requirements.⁴³ Pitched battles, not always purely partisan but often breaking along party lines, broke out within and between state legislatures and governors' offices. Gradually, the vast majority of states came to the table, committing to fund 10 percent of the costs of expansion in order to meet the federal government's 90 percent contribution.⁴⁴

Today, over twenty million people are covered under their state's Medicaid expansion program.⁴⁵ Federal, state, and local officials working together to implement the expansion effort not only supported their major urban health care systems' financial bottom line—which helped to fund cutting-edge care for entire regions and reinforced major jobs centers⁴⁶—but also supported their rural health care providers. This included clinics serving working-class areas, where many people fall in the limbo between being too poor to purchase health insurance out of pocket but earning too much to qualify for states' traditional, limited Medicaid. Opt-in states used the influx of funds to strengthen health care services across their states, including indigent care in hospitals, preventive services, substance abuse treatment, and mental health care.⁴⁷

43. Some states have, at various times, requested—and been granted—section 1115 waivers from the Centers for Medicare & Medicaid Services (CMS) in order to relax certain statutory requirements or allow states to add or substitute different policies as they implemented Medicaid expansion, such as covering Medicaid expansion beneficiaries via a “private option” rather than through traditional Medicaid coverage. See Gluck & Huberfeld, *supra* note 41, at 1737–40 (recounting “the third wave” of states to expand Medicaid by negotiating state-specific agreements with CMS); Bethany Maylone & Benjamin D. Sommers, *Evidence from the Private Option: The Arkansas Experience*, COMMONWEALTH FUND (Feb. 22, 2017), <https://www.commonwealthfund.org/publications/issue-briefs/2017/feb/evidence-private-option-arkansas-experience> (analyzing the adoption of the first such waiver in Arkansas). During the first Trump administration, CMS approved some states' applications to add work requirements. See Elizabeth Hinton, Jada Raphael & Amaya Diana, *Medicaid Work Requirements: Current Waiver and Legislative Activity*, KFF (Nov. 21, 2024), <https://www.kff.org/medicaid/medicaid-work-requirements-current-waiver-and-legislative-activity/> [<https://perma.cc/S95B-74L7>]. For an up-to-date overview of the status of each state's Medicaid expansion status, including section 1115 activity, see *Status of State Medicaid Expansion Decisions*, *supra* note 19.

44. See Elizabeth Williams, Alice Burns, Rhiannon Euhus & Robin Rudowitz, *Eliminating the Medicaid Expansion Federal Match Rate: State-by-State Estimates*, KFF (Feb. 13, 2025), <https://www.kff.org/medicaid/eliminating-the-medicaid-expansion-federal-match-rate-state-by-state-estimates/> [<https://perma.cc/J5Y7-TKJM>].

45. *Id.*

46. See MATTHEW BUETTGENS, REDUCING FEDERAL SUPPORT FOR MEDICAID EXPANSION WOULD SHIFT COSTS TO STATES AND LIKELY RESULT IN COVERAGE LOSSES 13–14 (2025).

47. Celli Horstman, Sara Federman, Carson Richards & Akeiisa Coleman, *How Does Medicaid Benefit States?*, COMMONWEALTH FUND (May 5, 2025), <https://www.commonwealthfund.org/publications/explainer/2025/may/how-does-medicaid-benefit-states>.

Some moderate Republican governors in conservative states have refused to treat Medicaid expansion as a purely partisan issue, deciding instead to embrace the chance to expand low-income health care coverage.⁴⁸ Yet ten opt-out states remain. As of this publication, 1.4 million people are locked out of expansion in Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming.⁴⁹ A second category of states (including Arizona, Arkansas, Illinois, Indiana, Montana, New Hampshire, North Carolina, Utah, and Virginia) have enacted so-called trigger laws, which would immediately revoke the state's approval of the Medicaid expansion program if the federal government ever backs away from the ACA's promise to fund 90 percent of Medicaid expansion.⁵⁰ Additional trigger laws were proposed earlier in 2025 (including in Ohio, South Dakota, and West Virginia), reflecting states' ongoing fears that D.C. politics will interfere with the single largest source of federal funding to states, leaving them with a larger program share they cannot afford.⁵¹

48. See, e.g., *In Their Own Words: Republican Governors Support Medicaid Expansion*, FAMS. USA (Jan. 12, 2017), <https://familiesusa.org/resources/in-their-own-words-republican-governors-support-medicaid-expansion/> [<https://perma.cc/6THX-HV PW>] (highlighting the eleven Republican governors who chose to expand Medicaid and their arguments in favor of the program, including support for low-income families, treatment of opioid addiction, fiscal support for hospitals, and state economic interests).

49. Cervantes, Bell, Tolbert & Damico, *supra* note 20. The coverage gap refers to adults who have incomes above their non-expansion state's eligibility threshold but earn too little to qualify for Marketplace subsidies. *Id.*

50. *Status of State Medicaid Expansion Decisions*, *supra* note 19. Three more states (Idaho, Iowa, and New Mexico) have more moderate trigger laws in place that specify steps the state must take to mitigate state costs if the federal medical assistance percentage falls. Adam Searing, *Federal Funding Cuts to Medicaid May Trigger Automatic Loss of Health Coverage for Millions of Residents of Certain States*, GEO. UNIV. MCCOURT SCH. OF PUB. POL'Y: CTR. FOR CHILD. & FAMS. (Nov. 27, 2024), <https://ccf.georgetown.edu/2024/11/27/federal-funding-cuts-to-medicaid-may-trigger-automatic-loss-of-health-coverage-for-millions-of-residents-of-certain-states/> [<https://perma.cc/9ZY6-F5CQ>].

51. *Status of State Medicaid Expansion Decisions*, *supra* note 19; *Policy Basics: Introduction to Medicaid*, CTR. ON BUDGET & POL'Y PRIORITIES (June 10, 2025), <https://www.cbpp.org/research/health/introduction-to-medicaid> (identifying Medicaid as constituting "over 50 percent of federally funded state spending in" an average year). Ohio's trigger law passed in July 2025. *Status of State Medicaid Expansion Decisions*, *supra* note 19. Coverage of the OBBBA negotiations revealed states' concern that their share of federal funding for their Medicaid expansion populations would be reduced, a proposal that ultimately did not pass Congress. See, e.g., Noah Weiland & Sarah Kliff, *As G.O.P. Eyes Medicaid Cuts, States Could Be Left with Vast Shortfalls*, N.Y. TIMES (Feb. 26, 2025), <https://www.nytimes.com/2025/02/25/us/politics/medicaid-cuts-republican-budget.html>; Catie Edmondson & Margot Sanger-Katz, *Johnson Rules Out an Aggressive Plan to Cut Medicaid as G.O.P. Moderates Waiver*, N.Y. TIMES (May 7, 2025), <https://www.nytimes.com/2025/05/07/us/politics/medicaid-cuts-house-republicans-johnson.html>; Paige Winfield Cunningham, Theodor Meyer & Dan

Medicaid expansion has proven so important to the working poor and rural health care providers in opt-in states that even conservative figures like U.S. Senator Josh Hawley have spoken in the program's defense.⁵² A fifth of Missourians now rely on Medicaid, he argued in the weeks leading up to the OBBBA's passage, and rural health providers in his state rely on the program "to keep their doors open."⁵³

B. The New Status Quo

Senator Hawley and other Republican lawmakers did not stop deep cuts to the program in the 2025 federal budget reconciliation bill, the OBBBA, and they ultimately voted for the bill along party lines.⁵⁴ That vote approved several dramatic reforms to the existing, nationwide Medicaid program as well as the opt-in expansion program. Total Medicaid cuts across the next decade were estimated to total \$911 billion and leave ten million additional people uninsured.⁵⁵

The first of these reforms—and one sure to affect the political chemistry of expansion—was the imposition of new, non-waivable work requirements for all beneficiaries who receive coverage through Medicaid expansion. Again, this population includes the individuals who earn between their state's traditional Medicaid eligibility and 138 percent of the Federal Poverty Line (FPL).⁵⁶ While most adults subject to work requirements are working or otherwise qualify for an exemption, much of the expected coverage loss will result from enrollees' issues with

Merica, *Republicans Fear Political Cost of Medicaid Cuts*, WASH. POST (May 9, 2025), <https://www.washingtonpost.com/politics/2025/05/09/republicans-political-cost-medicaid-cuts/>.

52. See Josh Hawley, *Josh Hawley: Don't Cut Medicaid*, N.Y. TIMES (May 12, 2025), <https://www.nytimes.com/2025/05/12/opinion/josh-hawley-dont-cut-medicaid.html>.

53. *Id.*

54. Kati Perry, Hannah Dormido & Nick Mourtoupalas, *How Every Senator Voted on the Reconciliation Bill*, WASH. POST (July 1, 2025), <https://www.washingtonpost.com/politics/interactive/2025/07/01/senate-big-beautiful-bill-vote-count/>.

55. Anna Mudumala, Maiss Mohamed, Jennifer Tolbert & Alice Burns, *The Impact of H.R. 1 on Two Medicaid Eligibility Rules*, KFF (Sep. 22, 2025), <https://www.kff.org/medicaid/the-impact-of-h-r-1-on-two-medicaid-eligibility-rules/> [https://perma.cc/CFV4-XDYN].

56. CTR. FOR HEALTH CARE STRATEGIES, MEDICAID WORK REQUIREMENTS IMPLEMENTATION SERIES: A SUMMARY OF FEDERAL MEDICAID WORK REQUIREMENTS 1–2 (2025), <https://www.chcs.org/media/A-Summary-of-Federal-Medicaid-Work-Requirements.pdf> [https://perma.cc/3A8R-BUAS].

administrative compliance—basically, with the paperwork.⁵⁷ This Essay will return to the effects of this reform on current politics in Part IV.

In addition to the new administrative burdens of proving and verifying employment, states also face more stringent Medicaid enrollment policies that will require more frequent, onerous eligibility reviews, bogging beneficiaries down in error-prone forms and easily missed deadlines.⁵⁸ The law also effectively repealed (for the next decade, at least) two Biden-era rules enacted to streamline the Medicaid bureaucracy and make it easier for people to enroll in and maintain coverage.⁵⁹

By driving large increases in the uninsured population, the combined effects of these laws will transfer new burdens to the local public sector in those regions where low-income households are concentrated.⁶⁰ Over the next ten years, counties are estimated to face \$1 trillion in new costs stemming from health care and other safety net cuts in the OBBBA.⁶¹ For example, county-supported health systems will see a dramatic rise in uncompensated care costs as they struggle to comply with their mandate to treat people who lack insurance.⁶² Concerns over the dire financial straits facing many rural health care systems led to a hastily negotiated \$50 billion fund for rural hospitals—one of the few health-related wins in the law⁶³—but that measure failed to soften the blow to urban centers that also serve large numbers of Medicaid patients.⁶⁴

57. See Jennifer Tolbert, Sammy Cervantes & Gary Claxton, *Different Data Source, But Same Results: Most Adults Subject to Medicaid Work Requirements Are Working or Face Barriers to Work*, KFF (June 25, 2025), <https://www.kff.org/medicaid/different-data-source-but-same-results-most-adults-subject-to-medicaid-work-requirements-are-working-or-face-barriers-to-work/> [https://perma.cc/N2YN-CFFB]; Jay Lau, *Previous Medicaid Coverage Losses Related to ‘Unwinding’ Shed Light on What to Expect from Future Cuts*, HARV. T.H. CHAN SCH. PUB. HEALTH (Oct. 16, 2025), <https://hsph.harvard.edu/news/previous-medicaid-coverage-losses-related-to-unwinding-shed-light-on-what-to-expect-from-future-cuts/> [https://perma.cc/YS64-QKC3].

58. See *Health Provisions in the 2025 Federal Budget Reconciliation Law*, KFF (Aug. 22, 2025), <https://www.kff.org/medicaid/health-provisions-in-the-2025-federal-budget-reconciliation-law/#2ca666ac-5d15-4454-8973-241566e22bb5> [https://perma.cc/9QVL-RQZB] (discussing section 71107 of the 2025 budget reconciliation law instituting more frequent Medicaid eligibility determinations).

59. Mudumala, Mohamed, Tolbert & Burns, *supra* note 55.

60. See Teryn Zmuda, Isabella Reed, Abby Davidson & Stacy Nakintu, *The Big Shift: An Analysis of the Local Cost of Federal Cuts*, NAT’L ASS’N OF CNTYS. (July 9, 2025), <https://www.naco.org/resource/big-shift-analysis-local-cost-federal-cuts> [https://perma.cc/K6W7-JFPJ].

61. *Id.*

62. *Id.*

63. Susanna Vogel, *A \$50B Rural Health Fund Was Negotiated with Hospitals in Mind. Experts are Split on Whether It Will Help Them at All.*, HEALTHCARE DIVE (Aug. 26, 2025), <https://www.healthcaredive.com/news/a-50b-rural-health-fund-was-negotiated-with-hospitals-in-mind-experts-are/757714/> [https://perma.cc/52T7-DPGL].

64. See Levinson, Hulver, Godwin & Neuman, *supra* note 14.

II. THE HISTORICAL CONTEXT OF A FEDERAL-LOCAL ALTERNATIVE

The upshot of health care reform under the Trump administration in 2025 will be millions of newly uninsured, low-income people. The task, then, is to reduce that number. Compensating for those losses compels a fresh look at federal-local partnerships, which have a long history in American lawmaking, including in health care and even the ACA itself.

A. *The “ACA’s Federalism”*

Since its inception, the rollout of the ACA has been a process of adaptation and compromise. “The Medicaid expansion did not play out as a battle between the national government and ‘the states’ as a collective,” wrote Abbe Gluck and Nicole Huberfeld in a seminal analysis of federalism in health care.⁶⁵ “Instead, the Obama Administration was a serial negotiator, inking distinct deals with individual states, all of which watched the others and then negotiated in their own interests.”⁶⁶ This degree of “dynamic and adaptive implementation” for Medicaid expansion and the state insurance exchanges made for a flexible, evolving model of “ACA’s federalism” that has survived changes in presidential administrations.⁶⁷

Intrastate politics were central to this strategy. Creative workarounds to avoid formal gubernatorial approval, for example, helped advance important aspects of state health care exchanges.⁶⁸ Dubbed by one of Gluck and Huberfeld’s interviewees the “secret boyfriend model,” some state actors wanted federal assistance but needed to avoid a veto from other parts of the state government.⁶⁹ State actions could be “so discreet,” the authors wrote, that it sometimes seemed “that one arm of the government was trying to hide its actions from another.”⁷⁰ Federal partners “even helped these states market their supposedly uncooperative exchange efforts to provide political cover.”⁷¹

65. Gluck & Huberfeld, *supra* note 41, at 1752.

66. *Id.*

67. *Id.* at 1689 (“The ACA’s federalism is defined not by separation between state and federal, but rather by a national structure that invites state-led implementation. As it turns out, that structure was only a starting point for a remarkably dynamic and adaptive implementation process that has generated new state-federal arrangements. States move back and forth between different structural models vis-à-vis the federal government; internal state politics produce different state choices; states copy, compete, and cooperate with each other; and negotiation with federal counterparts is a near constant.”).

68. *See id.* at 1770.

69. *Id.* at 1771.

70. *Id.* at 1770.

71. *Id.* at 1771.

These “secret boyfriends” and other low-profile negotiations operationalized the classic insight from Roderick Hills that public policy must sometimes “dissect the state[s].”⁷² That is, state and local governments should be viewed as an assortment of agencies, branches, and institutions rather than a unified “state government.”⁷³ Various parts of state government, he argued, “compete with each other for the power to control federal funds and implement federal programs.”⁷⁴ Gluck and Huberfeld’s legal history of ACA negotiations reads like an exhibit for this observation, as health care advocates inside and beyond the federal government built a political path of persuadable politicians, civil servants, and hospital administrators within their states.⁷⁵ Intrastate maneuvering came at some cost to transparency and accountability,⁷⁶ but these were arguably short-term, unavoidable downsides as health care became increasingly complex and politically fraught.

Importantly, this realism about intrastate politics liberated the ACA’s development from complete agreement about the most important rationales for Medicaid expansion or a state exchange. Equality, access, states’ rights, and other goals could coexist in a messy mix of motivations held by federal and state actors.⁷⁷ The Obama administration chose a pragmatic commitment to improving the reach of health care coverage in their opt-in negotiations with states, even where opt-ins required concessions and waivers that strayed from the original vision of the ACA.⁷⁸ Contrary to the common perception that partisanship alone dominates health care politics, the actual development of the ACA across the country suggests that varied legal structures and intrastate politics both necessitated and drove state-by-state differences.⁷⁹

Of course, this adaptive strategy did not manage to draw every last state into Medicaid expansion. The final block of opt-out states has, at times, seemed like a hardened wall of “no.” But between the imposition of national work requirements (historically a common sticking point for conservative states in their negotiations with the Obama and Biden administrations) and heavy fiscal losses anticipated for the hospitals and research complexes that serve as key economic engines for their regions, it is worth asking: What might be possible now?

72. Roderick M. Hills, Jr., *Dissecting the State: The Use of Federal Law to Free State and Local Officials from State Legislatures’ Control*, 97 MICH. L. REV. 1201, 1203 (1999).

73. *Id.* at 1201.

74. *Id.*

75. Gluck & Huberfeld, *supra* note 41, at 1740–46, 1758.

76. *Id.* at 1771.

77. *Id.* at 1698.

78. *Id.* at 1740.

79. *Id.* at 1747–51.

The federal government has hemorrhaged staff and political will to prioritize health care, but the civil servants and agency officials who have built Medicaid expansion have not all been pushed out. Federal programs and policies that rely on coordination directly with local governments fall within the space that Nestor Davidson has called “cooperative localism”⁸⁰ and Dave Owen has called “cooperative subfederalism.”⁸¹ This type of cooperation has been common across policy domains for more than a hundred years.⁸² As Davidson argues, such cooperation is consistent with the values prized by modern federalism at the Supreme Court, including “pluralism and the experimental values of decentralized governance” and “community and democratic participation.”⁸³ These analyses beg the question: Can this degree of dynamism carry over into locally based projects, like those at the origin of the ACA?

B. The Federal-Local Roots of the ACA: Section 1115 Waivers

Although localized Medicaid expansion was not encompassed by the ACA, it is not unprecedented. In fact, county-level projects in California, Illinois, Ohio, and Washington helped test localized Medicaid expansion in the years prior to its broader adoption through the ACA.⁸⁴ These “demonstration projects” developed under section 1115 of the Social Security Act,⁸⁵ which allows the Centers for Medicare & Medicaid Services (CMS) to waive certain federal requirements for states in order to test novel approaches, or “demonstration projects,” under the Medicaid program.⁸⁶ Originally established to give states the flexibility to run experimental, localized interventions to improve program

80. Nestor M. Davidson, *Cooperative Localism: Federal-Local Collaboration in an Era of State Sovereignty Part II: Federalism*, 93 VA. L. REV. 959, 960 (2007).

81. Dave Owen, *Cooperative Subfederalism*, 9 U.C. IRVINE L. REV. 177, 225 (2018). Owen rightly argued that it is a fallacy to collapse state and local governments into a single category. *Id.* Owen argues that *Sebelius* is a prime example of courts’ eliding the distinction: “[T]he independent power of the *States* also serves as a check on the power of the *Federal* Government,” which helps ensure that powers are ‘held by governments more *local* and more accountable than a distant federal bureaucracy.’” *Id.* at 226 (quoting *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 536 (2012) (emphasis added)).

82. Davidson, *supra* note 80, at 968–73 (noting that federal-local collaboration accelerated in the post-war period, grew through 1960s and 1970s direct revenue sharing and infrastructure investment by the federal government, and accelerated again post 9/11).

83. *Id.* at 961.

84. KATHLEEN FARRELL ET AL., COUNTY EXPERIENCES WITH MEDICAID EXPANSION IMPLEMENTATION: CASE STUDY REPORT 1–3, 4 (2016), https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/146891/CoExper.pdf.

85. *Id.* at vi–vii.

86. *See* 42 U.S.C. § 1315.

delivery,⁸⁷ section 1115 waivers have gradually become ways to pursue comprehensive, statewide projects that circumvent certain federal Medicaid requirements.⁸⁸

Early Medicaid expansion waiver projects were developed by state agencies working in close collaboration with the target counties. In Cook County, Illinois, for example, the county first approached the state with the idea of running a county-only demonstration project, which was eventually approved as the Illinois CountyCare Section 1115 Demonstration in 2012.⁸⁹ The project helped ready the Cook County Health and Hospitals System, and the state more broadly, for full Medicaid expansion.⁹⁰ In Ohio, too, the MetroHealth System in Cuyahoga County (which operates four hospitals and twenty health centers across Cleveland and its region⁹¹) first proposed the section 1115 project in response to the county's increased rates of uncompensated care in the years prior to the ACA.⁹² These demonstration projects had the discretion to adjust the Medicaid expansion program as needed to ensure early implementation efforts met their counties' needs and capacity. In Cuyahoga County, the program was capped at 36,000 enrollees,⁹³ in other early expansion waivers, such as California's Low-Income Health Program, counties had discretion to set the income threshold for eligibility.⁹⁴

In each of these cases, states navigated the complexity of Medicaid expansion by starting with their biggest urban hospital centers (*e.g.*, in

87. Anthony Albanese, *The Past, Present, and Future of Section 1115: Learning from History to Improve the Medicaid-Waiver Regime Today*, 128 YALE L.J.F. 827, 827–28 (2019), <https://yalelawjournal.org/article/the-past-present-and-future-of-section-1115> [<https://perma.cc/8U9R-ZURJ>].

88. *Id.* at 832.

89. FARRELL ET AL., *supra* note 84, at A-7 to A-8.

90. Samantha Artiga, *Profiles of Medicaid Outreach and Enrollment Strategies: The Cook County Early Expansion Initiative*, KFF (Apr. 7, 2014), <https://www.kff.org/medicaid/issue-brief/profiles-of-medicare-outreach-and-enrollment-strategies-the-cook-county-early-expansion-initiative/> [<https://perma.cc/Z8N7-N7C8>]; FARRELL ET AL., *supra* note 84, at A-7 to A-8.

91. See *The MetroHealth System, Ohio: Overview*, AM. HOSP. ASS'N, <https://www.aha.org/case-studies/2022-11-04-metrohealth-system-ohio> [<https://perma.cc/6L9G-QZR7>] (last visited Nov. 22, 2025).

92. This proposal was later approved as Ohio's MetroHealth Care Plus waiver program. FARRELL ET AL., *supra* note 84, at A-16 to A-17.

93. *Id.*

94. See Benjamin D. Sommers, Kao-Ping Chua, Genevieve M. Kenney, Sharon K. Long & Stacey McMorro, *California's Early Coverage Expansion Under the Affordable Care Act: A County-Level Analysis*, 51 HEALTH SERVS. RSCH. 825, 826 (2016); MAC TAYLOR, *THE 2013-14 BUDGET: EXAMINING THE STATE AND COUNTY ROLES IN THE MEDI-CAL EXPANSION* 15 (2013), <https://lao.ca.gov/analysis/2013/health/ACA/medi-cal-expansion-021913.pdf> [<https://perma.cc/73XQ-QXP3>].

Chicago, Cleveland, and Seattle). These demonstration projects temporarily advantaged urban residents of these counties but ultimately helped expand care statewide by developing and refining administrative systems and improving political will for expansion. They also took advantage of the resources and expertise of major hospital complexes and their established relationships with state and local entities.

To this day, strong, well-resourced counties have continued this tradition of leading health care coverage initiatives and infrastructure despite the administrative complexity of doing so. For example, counties in California have developed health insurance options for their uninsured residents who fall between the cracks of state and federal programs.⁹⁵ The idea of a county running a health insurance plan would have once sounded impossible—until they did it.

While these projects featured close state collaboration in addition to federal and local relationships, they serve as examples of how thriving coverage models can be built from below. Counties and cities have demonstrated that they can pioneer technically complex innovations in health care coverage.

III. POLICY MODELS

At this challenging crossroads for low-income health care access and coverage, can crisis drive creativity? Is there a path for committed local entities—such as multicounty partnerships working with the health care sector—to cooperate with federal partners and build something that does not need high-level state approval? Even if a gubernatorial signature or some degree of state executive cooperation may be needed, could a local focus allow an outwardly begrudging governor to sign in the name of “protecting our hospitals” rather than “health care for all”?

This Part surfaces four models for a locally led path to help restart the politics of expansion. The first is a more traditional statutory fix to Medicaid proposed by federal Democratic lawmakers in the South—an approach that warrants more careful legal and policy analysis for bipartisan adaptation, or at least as a future plan for Democrats if they retake the congressional majority. The second strategy, which would appeal more to those averse to building Medicaid as a traditional safety-net program, contemplates solutions within the existing ACA marketplaces. A third path leverages federal grantmaking for local governments to increase localities’ capacity to provide critical health care services, something that could be accomplished in the short term without disturbing existing coverage systems. Lastly, this Part describes the ways

95. See HEALTH ACCESS CALIFORNIA, COUNTY HEALTH CARE ACCESS FOR UNINSURED CALIFORNIANS 1–3 (2024), https://health-access.org/wp-content/uploads/2024/08/2024_County-Indigent-Care_fnl.pdf.

that the existing section 1115 pathway remains an option for local expansion in states seeking a lower profile way to reinforce hospitals without opting into Medicaid expansion statewide.

A. Statutory Medicaid-Based Approaches

A locally led solution can, of course, start with the Medicaid expansion model itself. As the trickle of states opting in began to slow and the line between expansion and non-expansion states grew more entrenched, Democratic congressional representatives in opt-out states put forward the Cover Outstanding Vulnerable Expansion-eligible Residents (COVER) Now Act. Introduced in each session of Congress since 2021, the COVER Now Act aims to create a local opt-in choice within Medicaid.⁹⁶ The proposal mirrors the Medicaid expansion offer previously made available to states. For the first three years, federal funding would cover 100 percent of the demonstration project, followed by a gradual reduction to 90 percent federal funding by year seven and into extension years.⁹⁷

The COVER Now Act would amend Title XIX of the Social Security Act to authorize Medicaid demonstration projects for local governments to expand Medicaid to their expansion populations.⁹⁸ It would enable the federal CMS to work directly with counties, cities, and other political subdivisions working alone or in groups. A local government or partnership of local governments would, after undergoing notice-and-comment procedures, submit a proposal to the United States Department of Health and Human Services (HHS) to provide Medicaid to its expansion population for seven years (or until its State adopts the Medicaid expansion).⁹⁹ The bill allows a local government to extend the demonstration project for an additional five years.¹⁰⁰ CMS would approve and then collaborate on implementation of a local-level Medicaid expansion program. The program resembles the waivers established under section 1115 of the Social Security Act (previously described in Section II.B). Unlike existing section 1115 authority, however, COVER Now would not require that

96. See Cover Outstanding Vulnerable Expansion-eligible Residents Now Act (COVER Now Act), H.R. 3961, 117th Cong. (2021); Cover Outstanding Vulnerable Expansion-eligible Residents Now Act (COVER Now Act), H.R. 31, 118th Cong. (2023); Cover Outstanding Vulnerable Expansion-eligible Residents Now Act (COVER Now Act), H.R. 608, 119th Cong. (2025).

97. H.R. 608 § 2(a)(2). Existing Medicaid rules and systems would also remain in place and apply to local expansion programs.

98. *Id.*

99. *See id.*

100. *Id.*

a state lead the project application to CMS, but rather would empower local entities to do so independently of their states.

While the COVER Now proposal builds on what is familiar and appeals to those who prefer coverage expansions to remain rooted in Medicaid, the law has threshold legal and administrative complications. The first of these relates to the anti-commandeering guardrail on federal lawmaking.¹⁰¹ Recognizing the difficulties that counties might face in implementing the local-level Medicaid expansion, the COVER Now legislative proposal preempts certain implementation challenges through a number of provisions prohibiting states from taking retaliatory or obstructive actions.¹⁰² Among other limitations, the bill prohibits states from interfering with local entities' access to and reliance on state Medicaid systems and staff to implement the local-level Medicaid expansion.¹⁰³ The bill tries to sidestep anti-commandeering challenges with federal funding, but the mechanics of implementation might well require states to take affirmative steps to share eligibility screening tools, databases, or other resources with local governments.

Without definitive facts detailing these steps within any given state (*i.e.*, an itemized list of local governments' technical needs for program implementation), this Essay cannot engage in an anti-commandeering analysis here. But as a practical matter, state officials or outside interests who view Medicaid expansion as an insidious form of "welfare" can bring anti-commandeering challenges to prevent opt-in localities from pursuing a COVER Now option. The extreme risk of litigation on this issue means that federal lawmakers should consider reissuing this bill without prohibitions on state non-cooperation. The practical downside of cutting these prohibitions from the bill, however, is that local governments may be forced to mount their own technical systems for Medicaid expansion eligibility and enrollment where states withhold access to existing infrastructure—a self-evidently complex and expensive prospect that creates an inefficient redundancy with state bureaucracy. Preferable alternatives to this cumbersome path would include the following: localities could independently seek access to state systems through a contract-based memorandum of understanding; federal funding could cover state costs of compliance, which could help deter state-led

101. *See Printz v. United States*, 521 U.S. 898, 930–33 (1997) (holding that Congress impermissibly commandeered state officials under the Brady Handgun Violence Prevention Act when it temporarily required state officials to support a federal background check program).

102. H.R. 608, 119th Cong. § 2(a)(2).

103. *Id.*

anti-commandeering lawsuits;¹⁰⁴ or small, technical units within state government could permit use of state systems in ways reminiscent of the “secret boyfriends” described in Section II.A.

A second major impediment to solutions like COVER Now is that funding an eventual 10 percent of the program costs is a significant, potentially existential limitation for many counties. Furthermore, the actual mechanics of implementing a local-level expansion would be daunting for counties, which generally do not interface much with their residents’ enrollment in the traditional state Medicaid programs.¹⁰⁵ The only feasible target groups for local solutions are thus the most populous urban counties (likely working together), which are often those who bear the greatest cost burden from uninsured people in the coverage gap. Fiscal analysis of Medicaid expansion suggests that states reap long-term budget advantages from funding health insurance up front.¹⁰⁶

Recognizing the difficulty of disturbing the Medicaid statutory framework both legally and administratively, the question of how else local governments might expand coverage for some of their most vulnerable populations may require venturing beyond Medicaid.

B. ACA Marketplace Solutions

In addition to Medicaid expansion, a second major prong of the ACA created health insurance exchanges, or “marketplaces,” to help individuals and families access health care coverage. ACA premium tax credits and other forms of cost sharing have helped make coverage more affordable, including for those with incomes above 138 percent of the federal poverty rate (*i.e.*, those who are not eligible for Medicaid even

104. See Neil S. Siegel, *Commandeering and Its Alternatives: A Federalism Perspective*, 59 VAND. L. REV. 1629, 1656–57 (2006) (hypothesizing that the rarity of anti-commandeering litigation is related, in part, to the federal government’s effective use of spending to minimize costs to states).

105. In California and New York, counties help manage initial eligibility screening and checks. See STAN ROSENSTEIN, CAROLINE DAVIS & DAVID ROSDICK, FINANCING COUNTY MEDI-CAL ELIGIBILITY AND ENROLLMENT IN CALIFORNIA 2–3 (2012), <https://www.chcf.org/wp-content/uploads/2017/12/PDF-FinancingCountyMediCal.pdf> [<https://perma.cc/4YZ7-Q758>]; *How to Apply for NY Medicaid*, DEP’T OF HEALTH (Aug. 2025), https://www.health.state.ny.us/health_care/medicaid/how_do_i_apply.htm [<https://perma.cc/JK2P-6TPE>] (requiring certain groups complete applications through the county-level Local Department of Social Services). In most, if not all, other states, eligibility verification is managed at the state level—an increasingly onerous task as the 2025 federal budget reconciliation law raises requirements for eligibility, including via work requirements and more frequent re-eligibility determinations. One Big Beautiful Bill Act, Pub. L. No. 119-21, §§ 71107, 71119, 139 Stat. 72, 295–96, 306–15 (2025).

106. See Ward, *supra* note 32; Horstman, Federman, Richards & Coleman, *supra* note 47.

under the expansion).¹⁰⁷ These marketplaces offer another option for existing infrastructure that could provide the foundation underlying new federal-local cooperation in health care coverage.

The Milbank Memorial Fund, a nonpartisan research and health care foundation,¹⁰⁸ has proposed one such model. Milbank envisions a “Local Choice Option” that would allow local entities (such as counties, cities, or groups of counties) to establish an optional insurance program operating alongside the Marketplace.¹⁰⁹ This proposal would tackle the same problem addressed by the COVER Now Act—expanding coverage for people in a non-expansion state that would otherwise qualify for Medicaid.¹¹⁰ Mechanically, the program would give local governments “access to funds for the purchase of an insurance product for uninsured, non-elderly, documented individuals with incomes under 100 [percent] of the FPL.”¹¹¹

Reliance on Marketplace infrastructure, as opposed to state Medicaid programs, could allow local entities to work around their states in a federal-local cooperative funding and administrative arrangement. The proposal sidesteps CMS and its Center for Consumer Information and Insurance Oversight (CCIIO), instead proposing the Health Resources and Services Administration (HRSA) as a federal administrative partner.¹¹² Indeed, the new insurance program would operate entirely outside of Medicaid, though it would offer “a ‘Medicaid look-alike’ benefit” that replicated each state’s Medicaid benefits.¹¹³ Without CMS and its existing partnership with and reliance on state Medicaid programs, the proposal seems to avoid the issue of commandeering states, helped along by the fact that nearly all of the non-expansion states rely on the federally facilitated Marketplace, as opposed to their own state-run exchanges.¹¹⁴ There would also be no entitlement

107. *Key Facts: Premium Tax Credit*, CTR. ON BUDGET & POL’Y PRIORITIES: BEYOND THE BASICS (Aug. 2024), <https://www.healthreformbeyondthebasics.org/premium-tax-credits-answers-to-frequently-asked-questions> [https://perma.cc/RXG2-CHQL].

108. MILBANK MEMORIAL FUND, <https://www.milbank.org/> [https://perma.cc/W8ER-E3VU] (last visited Nov. 3, 2025).

109. JACK MEYER, MATT POWERS & NORA LEIBOWITZ, MILBANK MEM’L FUND, CONSIDERATIONS FOR A LOCAL HEALTH INSURANCE OPTION IN MEDICAID NON-EXPANSION STATES 2 (2022), https://www.milbank.org/wp-content/uploads/2022/02/LC_3_final.pdf [https://perma.cc/74MZ-UJXB].

110. *See id.* at 6–7.

111. *Id.* at 2.

112. *See id.*

113. *Id.* at 3.

114. Nine of the ten non-expansion states rely on the federally facilitated marketplace. *See State Health Insurance Marketplace Types*, KFF, <https://www.kff.org/affordable-care-act/state-indicator/state-health-insurance->

structure; it could be phased in, local entities could set different eligibility criteria, and they could discontinue the program at any time.¹¹⁵ As with the COVER Now Act, the model calls for the 90 percent federal funding share characteristic of Medicaid expansion, with the participating local entity funding the 10 percent non-federal share typically borne by expansion states.¹¹⁶

Setting aside the financial burden, significant administrative and technical obstacles remain. Milbank suggests HRSA as a potential administrative partner, citing its existing relationships with localities.¹¹⁷ The new infrastructure required for HRSA to administer a Local Choice Option—including eligibility checks, payment, and billing systems—would be significant. HRSA’s existing local programs are largely grant-based, and the agency does not share CMS’s complex regulatory infrastructure to ensure baseline quality care and coverage.¹¹⁸ In addition to the challenges of the proposed federal administrative partner, the proposal relies on the federal government executing significant logistical and structural adjustments, including building functionality for a Local Choice Option alongside the Marketplace and creating and sustaining a centralized business operation for the program—which the proposal refers to as similar to the federally facilitated Marketplace.¹¹⁹ The administrative barriers and complexities of such an option, from the federal perspective, are considerable.

Other offshoots of the ACA may also be worth exploring, building on the history of rich and dynamic federal-state collaboration—both celebrated and unsung—that emerged in the wake of the ACA and *Sebelius* in particular. The existing state option to create a “Basic Health Program,” for example, might provide a serviceable model for a potential local option. Instead of states covering populations ineligible for Medicaid expansion (for example unqualified non-citizens or people with incomes between 133 and 200 percent FPL),¹²⁰ the Basic Health

marketplace-types/ [https://perma.cc/F84P-YXYG] (last visited Oct. 4, 2025) (from “Locations,” select “Alabama,” “Florida,” “Georgia,” “Kansas,” “Mississippi,” “South Carolina,” “Tennessee,” “Texas,” “Wisconsin,” and “Wyoming”). Georgia transitioned to a state-based marketplace in 2025. *Id.* at n.2.

115. MEYER, POWERS & LEIBOWITZ, *supra* note 109, at 3, 7.

116. *Id.* at 3.

117. *Id.*

118. See generally *Policies, Regulations, and Guidance*, HRSA, <https://www.hrsa.gov/grants/manage-your-grant/policies-regulations-guidance> [https://perma.cc/4CRY-THET] (last visited Oct. 4, 2025) (providing guidance on policies and procedures for HRSA grant recipients).

119. MEYER, POWERS & LEIBOWITZ, *supra* note 109, at 5.

120. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1331, 124 Stat. 119, 199–203 (2010) (codified at 42 U.S.C. § 18051); *Basic Health Program*, MEDICAID.GOV, <https://www.medicaid.gov/basic-health-program> [https://perma.cc/Z78Q-5PBV] (last visited Oct. 4, 2025).

Program framework could be adjusted to allow local governments to access federal financing to expand coverage for people left out of their state's traditional Medicaid program.

Carving a niche for local entities within the complex, layered network of federal-state health care coverage may require this kind of creativity, just as states have experimented widely and with varying success over the last fifteen years.¹²¹ Furthermore, reforms that are based outside Medicaid itself but still target segments of the low-income population may prove less politically fraught to those wary of expanding Medicaid and committing to an indefinite entitlement or crossing their state's entrenched Medicaid expansion politics.

C. Enhanced Grantmaking

Eschewing the complexities of both Medicaid and the Marketplace, a third option for federal-local collaboration is the comparatively familiar ground of grantmaking. Grant-based relationships are fundamental to most federal-local cooperation today across sectors, including health care. HRSA, for example, oversees a number of rural health-related grant programs for which local entities may apply,¹²² in addition to supporting Federally Qualified Health Centers, some of which are run by municipal governments.¹²³ The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control (CDC) and Prevention both disburse funding directly to local entities to provide addiction and mental health services and chronic disease preventive services, respectively.¹²⁴ The federal response to the COVID-19 pandemic also experimented with new opportunities for federal

121. Gluck & Huberfeld, *supra* note 41, at 1767–71 (describing the range of state approaches to implementing the ACA marketplace provisions).

122. See, e.g., *Rural Health Care Services Outreach Program*, HRSA, <https://www.hrsa.gov/grants/find-funding/HRSA-25-038> [<https://perma.cc/7J79-YBNX>] (last visited Oct. 4, 2025).

123. See Sanjay Kishore, Micah Johnson & Rahul Nayak, *Characteristics of Public vs. Private Federally Qualified Health Centers*, 37 J. GEN. INTERNAL MED. 987, 987 (2021).

124. See, e.g., *Strategic Prevention Framework - Partnerships for Success (SPF-PFS) Grant Program*, SAMHSA (Dec. 17, 2024), <https://www.samhsa.gov/substance-use/prevention/strategic-prevention-framework-partnerships-success>; SAMHSA, *STRENGTHENING MENTAL HEALTH AND RESILIENCE AFTER COMMUNITY VIOLENCE: A SUMMARY OF LESSONS LEARNED FROM ReCAST 1* (2024), <https://library.samhsa.gov/sites/default/files/lessons-learned-recast-pep24-01-009.pdf> [<https://perma.cc/DL44-8WV4>] (describing the goals and communities served by SAMHSA's Resiliency in Communities After Stress and Trauma (ReCAST) grant program); *DNPAO State and Local Funding*, CDC (Nov. 20, 2024), <https://www.cdc.gov/dnpao-state-local-programs/php/funding-by-state> [<https://perma.cc/3BBH-W5B8>] (describing state and local grants supported by the CDC's Division of Nutrition, Physical Activity, and Obesity).

funding going to counties and cities, including through the CDC's Public Health Infrastructure Grant program, which certain counties and cities were eligible to receive directly.¹²⁵

While these kinds of federal-local grant-based relationships have largely been in the public health sphere, they could be adapted to help local entities gap-fill coverage needs in non-expansion states. For example, a grant-based effort could increase local governments' capacity to cover the critical health care services that some of their most vulnerable populations need and offset costs of uncompensated care. As with many new grantmaking programs, the proposal is vulnerable to the vagaries of appropriations and the perpetual need for reauthorization. Its administration, however, would be relatively simple and has the advantage of meeting local entities where they are in terms of both receiving and spending federal dollars. Initial planning should begin with an assessment of the costs of and gaps in health care coverage that counties in non-expansion states currently experience when it comes to uncompensated care for the coverage-gap population. This phase would identify where targeted federal funding might make the most impact.

D. Section 1115 Waivers

Finally, the changed politics of 2025 warrant a fresh look at existing statutory authorities, namely, state-led section 1115 waivers. The waivers originated as a method of supporting localized demonstration projects.¹²⁶ While they became a vehicle in the Obama administration for tailoring massive statewide Medicaid expansion programs,¹²⁷ a state-led return to those local roots might be more politically palatable today, offering states a lower-profile way to meet the demands of local stakeholders and to reinforce key hospital economies without opting into statewide expansion.

As previously discussed in Section II.A, conservative states successfully used section 1115 waivers to craft bespoke Medicaid expansion programs, such as in Arkansas, which received federal approval for a "private option" that used Medicaid funds to purchase

125. *Public Health Infrastructure Grant*, CDC (Mar. 14, 2024), <https://www.cdc.gov/infrastructure-phig/about/index.html> [https://perma.cc/DJ8Y-DS4B].

126. Anthony Albanese, *The Past, Present, and Future of Section 1115: Learning from History to Improve the Medicaid-Waiver Regime Today*, 128 YALE L.J.F. 827, 827–28 (2019), <https://yalelawjournal.org/article/the-past-present-and-future-of-section-1115> [https://perma.cc/V285-HJDG].

127. See Elizabeth Hinton & Amaya Diana, *Medicaid Section 1115 Waivers: The Basics*, KFF (Jan. 24, 2025), <https://www.kff.org/medicaid/medicaid-section-1115-waivers-the-basics/> [https://perma.cc/4V5N-F8SC] (identifying 2014 to 2017 as a period in which section 1115 waivers facilitated alternative Medicaid expansion models).

private coverage for its expansion population.¹²⁸ These kinds of alternative, privatized federal-state arrangements could inspire a smaller-scale waiver application that seeks to opt in to expansion for a multicounty partnership, designed to offset the post-2025 fiscal losses for major hospital complexes and dependent local economies.

Other features of the OBBBA further bolster the political case for this kind of state-led application. One of the perennial stumbling blocks to expansion in opt-out states has been their insistence that any version of Medicaid expansion include robust work requirements. While the Obama and Biden administrations rejected those applications¹²⁹ and courts froze many of the first Trump administration's grants of section 1115 waivers featuring work requirements,¹³⁰ the OBBBA has now made work requirements a mandatory, nationwide feature of Medicaid expansion.

The combination of privatized models of expansion, proposals scaled at the county level, and mandatory work requirements might just make a localized expansion project more politically palatable for certain states.

IV. POLITICS AND OPEN QUESTIONS

At a time when Medicaid coverage is shrinking rather than expanding, it is counterintuitive to focus on new programs and populations. But we write from a position of opportunism as well as optimism when considering whether new stresses on the system may also create new political space in which to move.

The first new motivating factor is that, as previously described, lawmaking in 2025 will put hospitals and other health care actors under new fiscal pressures from falling revenues and insurance losses. The health care sector exerts tremendous influence on state and local economies, which may drive political and social pressure to come up with ways to expand health insurance access and minimize the growth of their uninsured populations. Having lost federal revenue from one source, that is, they may wish to opt in to new federal Medicaid resources available

128. Maylone & Sommers, *supra* note 43.

129. Madeline Guth & MaryBeth Musumeci, *An Overview of Medicaid Work Requirements: What Happened Under the Trump and Biden Administrations?*, KFF (May 3, 2022), <https://www.kff.org/medicaid/an-overview-of-medicaid-work-requirements-what-happened-under-the-trump-and-biden-administrations/> [https://perma.cc/NGV3-2RXX].

130. See Madeline Guth, Elizabeth Hinton, MaryBeth Musumeci & Robin Rudowitz, *The Landscape of Medicaid Demonstration Waivers Ahead of the 2020 Election*, KFF (Oct. 30, 2020), <https://www.kff.org/affordable-care-act/the-landscape-of-medicaid-demonstration-waivers-ahead-of-the-2020-election/> [https://perma.cc/DU5Q-7JGK].

elsewhere. Alliances of industry leaders working with county officials can propose locally viable experiments that draw from Medicaid expansion models in other states. Refined federal legislation to enable localized Medicaid- or Marketplace-based experimentation, as well as grant-led projects or creative use of existing section 1115 waiver authority, offer pathways that might avoid some of the pitfalls of the usual federal-state dynamics inherent in the Medicaid debates. Approaches such as these (or other models that could emerge from early negotiations) may require relatively low-profile conversations.

Even if pluralities of conservative state legislatures see the wisdom of protecting their big city hospital complexes from the cuts of 2025, they may need political cover to do so. The work requirements in the OBBBA (previously described in Section I.B) may provide some of that political cover for conservatives who favor expanded health care access. That is, conservative state lawmakers may be more receptive to Medicaid expansion given that it is now a program strictly available to low-income people with provable, consistent employment or who otherwise fall into an exception—a defining feature of the waiver requests that traditionally conservative states have requested across different federal administrations.¹³¹

Comparatively lower-profile, local opt-in policies (especially multicounty partnerships that create buy-in across large, multiracial, and bipartisan Metro areas) could allow state leaders to protest “Obamacare” in public even as they invest in the fiscal health and competitiveness of their state’s health care complexes. This kind of flexible, adaptive policy experimentation—including the behind-the-scenes negotiations described in Section II.A—has defined the trajectory of the ACA from its pre-enactment period through a decade of deals that drew states into Medicaid expansion.

It bears repeating that this path is littered with legal, political, and feasibility challenges. Here are two more, as yet unmentioned. The first is that the remaining opt-out states have majoritarian political cultures that are dominated by rural interests and lawmakers. Local governments in these states are, generally speaking, legally weaker. And the past twenty years or so of so-called “Red State/Blue City” conflicts have further depleted these governments’ authority and resources.¹³² But urban counties need not carry the administrative burden alone if central cities’ biggest hospitals, university medical schools, and other industry

131. Guth & Musumeci, *supra* note 129.

132. See, e.g., Richard C. Schragger, *The Attack on American Cities*, 96 TEX. L. REV. 1163, 1213–15 (2018); Richard Briffault, *The Challenge of the New Preemption*, 70 STAN. L. REV. 1995, 1995 (2018).

providers help lead program mechanics.¹³³ Technical assistance and planning grants from philanthropies and federal agencies (of the kind once used to support ACA implementation) can help build decision-making and partnership structures.

Emphasizing the role of hospitals and health care industry leaders both in administration and implementation as well as in political strategy will help to quantify, then elevate, the economic and jobs-based arguments that may prove more politically palatable to the usual opponents of Medicaid expansion. These include arguments based on the number and quality of jobs put at risk by health care cuts and the ancillary “main street” businesses that depend on major health care centers for their paychecks. That is not to say that the humanitarian interest in health care coverage for low-income patients is any less compelling—just that diversifying the arguments deployed may help tailor the debate in terms most persuasive to target audiences.

The Red State/Blue City conflict creates a second barrier to Medicaid expansion as well. Such cities are the home of the biggest health care complexes in the South and the opt-out states of the Midwest, but these cities’ liberal-leaning majorities make them maximally vulnerable to state non-cooperation, if not interference. Multicounty partnerships are the best approach to diffuse this polarization because they will diversify the partisan affiliation and racial composition of expansion beneficiaries.

Here again, Jackson, Mississippi, provides a good example. The three most populous counties of its metro area create a formidably diverse political coalition, as expressed in their 2024 presidential vote: Hinds County voted 72.4 percent for Kamala Harris, Rankin County voted 73 percent for Donald Trump, and Madison County voted 58 percent for Donald Trump.¹³⁴ These three counties also represent three of the ten counties in the state with the highest absolute numbers of uninsured people at or below 138 percent of the FPL.¹³⁵ Even as Rankin and Madison Counties are majority white and Hinds is majority black, all three counties are quite diverse by national standards, with the black population ranging from 21.6 percent in Rankin to 37.3 percent in

133. For an example of local governments working in complex partnership arrangements with hospitals and higher education, see MICHELLE WILDE ANDERSON, *THE FIGHT TO SAVE THE TOWN: REIMAGINING DISCARDED AMERICA* 131–35, 174–82 (2022).

134. Angela Williams, *Mississippi Presidential Election Results: County by County Breakdown*, 16 WAPT ABC, <https://www.wapt.com/article/mississippi-election-results-president/62569386> [<https://perma.cc/LDM9-76XG>] (last visited Oct. 30, 2025).

135. Larry Smith, *Uninsured Adults by County | 2025 Update*, CTR. FOR MISS. HEALTH POL’Y (Sep. 22, 2025), <https://mshealthpolicy.com/2025/09/22/uninsured-adults-by-county-2025-update/> [<https://perma.cc/N4AT-4FQ4>].

Madison and 72.4 percent in Hinds.¹³⁶ Deep racial and class divisions cut across and among these counties to be sure, but all three county governments bear the public costs of serving large uninsured populations. And all three of them count on access to outstanding and highly specialized care in the care complexes concentrated in the city of Jackson, giving them a linked fate with those hospitals' fiscal pictures.

Identifying counties by name reiterates the degree to which a local Medicaid expansion leaves uncovered counties behind. But locally led strategies take a step towards statewide adoption because they may rebuild momentum and generate political will to reach rural areas and smaller cities as well. Even legally or politically uncertain negotiations may be useful advocacy tools because they can enable the health care industry to calculate and advertise what they and their patients (across income brackets) will lose or gain from changes to state and federal Medicaid policy.

Creating new, organized constituencies who have experienced the humanitarian, workforce, and fiscal benefits of low-income health care access may also, over the longer run, help insulate Medicaid expansion from further degradation in federal politics. In that way, while nothing in this Essay helps directly address the brutal coverage losses that the OBBBA will trigger in opt-in states, raising political support for subsidized health care in non-expansion states is critical for the long-term survival of Medicaid.

CONCLUSION

The *Sebelius*-instigated transition into a state-choice model has created a nationwide patchwork of Medicaid eligibility and coverage. In states where the politics of expansion have stalled or reached a dead-end, medical facilities and local governments are limited to their state's traditional Medicaid eligibility even as they shoulder the burdens of the uninsured or under-insured population. Locally led models of Medicaid expansion could improve health care access for a share of chronically underserved people, generate new allies for working-class access to health care, and mitigate worrying trends in hospital and clinic closures. These models are not first-best solutions for either coverage or administrative ease, but we are not living in first-best times when it comes to affordable health care.

136. *Mississippi Population – Map*, NAT'L INST. ON MINORITY HEALTH & HEALTH DISPARITIES, https://hdpulse.nlmhd.nih.gov/data-portal/social/map?socialtopic=070&socialtopic_options=social_6&demo=00022&demo_options=pop_12&race=00&race_options=raceall_1&sex=0&sex_options=sex_3&age=001&age_options=ageall_1&statefips=28&statefips_options=area_states [https://perma.cc/C2H7-WS97] (last visited Oct. 30, 2025).

The audience for locally led proposals might include lawmakers like Jason White, the Republican Speaker of the Mississippi House and one of the state's most prominent advocates for Medicaid expansion. "If expanding Medicaid coverage was purely a business decision, it would have already been made," Speaker White argued last November while talking to a local Rotary Club about the issue.¹³⁷ "[Failing to adopt expansion] is a drag on our business economy. It's a drag on our health care economy and the delivery of health care It's time we had real adult conversations about the best path forward for our state and finding a way to cover these individuals."¹³⁸ Politics, however, have never quite allowed Speaker White's views to prevail in Mississippi. A ground-up strategy—one that emphasizes the post-2025 fiscal impacts to the state's biggest hospitals and enables counties to make their own choices about Medicaid expansion—may help Speaker White and others like him to secure the health care access they have been fighting for.

137. Emma McRae, *House Speaker Hopes for More Support for Medicaid Expansion*, COM. DISPATCH (Nov. 19, 2024), <https://cdispatch.com/news/house-speaker-hopes-for-more-support-for-medicaid-expansion/> [https://perma.cc/J5AK-DQ7B].

138. *Id.*

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