SHARE

COMMENTARY

Advocacy for Medicaid Expansion—Tale of Two Americas

Mark D. Schwartz, MD

Dr. Schwartz is professor of population health at the NYU School of Medicine and chair of the SGIM Health Policy Committee.

The triple aim of the Affordable Care Act (ACA) is to improve health, care, and cost in the United States. Expanding access to health care through public and private insurance reform is one of the pillars supporting these aims, and Medicaid policy is a major lever in expanding access to care.

The ACA leveled a very uneven playing field by requiring all states to expand their Medicaid programs and mandating coverage of adults with an annual family income up to 133% of federal poverty level (FPL) in 2014. Before the ACA, the threshold for Medicaid eligibility averaged 72% of FPL for all states but ranged from 11% (LA, AL) to 200% (MN, WI, ME, DC). States (mainly "Blue") that opted into Medicaid expansion early will receive 100% of the cost for newly eligible beneficiaries, thus maximizing their share of federal funds available for this expanded coverage. This federal support drops to 95% in 2017 and 90% after 2019. It is a very good deal for states.

The ACA was designed to provide Medicaid coverage to almost 17 million uninsured Americans. By expanding coverage to childless adults and setting national eligibility standards, the ACA aimed to end the historical distinction between the deserving and non-deserving poor that dates back to the Elizabethan era. Earlier this year, the US Supreme Court ruled, however, that mandating Medicaid expansion was unconstitutional. It was seen as coercive since states had to accept the new policy in order to maintain their federal Medicaid funding.

As of January 2015, 27 states plus Washington, DC, have opted into Medicaid expansion; 23 states (mainly "Red") have not yet expanded, but four of these are considering it (IN, TN, UT, WY). These states are delaying this policy decision for three core reasons: 1) political opposition to the ACA; 2) refusal to expand a perceived failed social policy into an enlarged entitlement program; and 3) getting stuck with a growing bill after 2019. These predominantly Southern or Midwestern states tend to be led by Republican governors or legislatures. They have greater numbers of uninsured citizens, greater poverty, lower educational achievement, and lower performance in state health rankings.

The decision to adopt or reject Medicaid expansion has significant health and economic consequences. A 2014 Massachusetts study found that for every 830 additional people who received coverage, one premature death was prevented.[1] Hospitals in states not expanding Medicaid coverage will have declining revenue since they will need to care for uninsured patients while losing their disproportionate share hospital (DSH) federal subsidy. DSH payments have offset uncompensated care and are set to decrease in the ACA. In contrast, hospitals in expansion states are already seeing a substantial decrease in the proportion of self-pay and charity care cases.

Making matters worse, 19 of the 23 states opting out of Medicaid have also chosen not to establish their own health insurance exchange. Instead their citizens rely on the federally run exchange for private health insurance on the individual market. This core ACA provision is now threatened by King v. Burwell, a case the US Supreme Court agreed to hear in early 2015. (The high court will issue its decision by June 2015.) The petitioners challenge the authority of the Internal Revenue Service (IRS) to subsidize health coverage purchased through insurance exchanges run by the federal government. They argue that Congress intended to limit federal tax credits to residents of states running their own insurance exchanges. Currently only 13 states and the District of Columbia operate exchanges on their own. Another 10 are in partnership with the federal government, and the rest are run by the federal government and would be threatened if the Court rules in favor of the plaintiff.

If the Court rules that subsidies in federal exchanges are not allowed, the IRS must stop paying such subsidies. Almost 5 million people are currently receiving subsidies in affected states, and this number will increase to 13 million by 2016. Many of those who could lose subsidies would no longer be required to have insurance because of an exemption for those who have to pay more than 8% of family income for premiums. This would topple the three-legged stool of guaranteed issue, mandated coverage, and premium support.

As we said in 2012, these forces may lead to a perfect storm for academic health centers in non-expanding states—continued large numbers of uninsured, loss of DSH payments, and no new cost-shifting to the insured to make up the difference.[2]

Because the potential impact on primary care is great and the bandwidth of our volunteer SGIM advocates is limited, lobbying efforts have been focused on national

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health policy. The Health Policy Committee (HPC) is willing to also lend support to local advocacy champions in states considering Medicaid expansion. State hospital associations[3] are actively advocating for coverage expansion since they agreed to substantial Medicare payment cuts in exchange for the promise of fewer uninsured patients. Local provider organizations[4] (e.g. American College of Physician chapters) offer another avenue for SGIM members to get involved in efforts to motivate State governors and legislatures to support Medicaid expansion as a health and economic issue.

If the Court blocks premium subsidies on the federally run exchanges, many more SGIM members will have cause to advocate locally for the establishment of a state-run insurance exchange to maintain coverage and access for our patients.

Please contact the HPC if you desire our support in implementing state-focused advocacy.[5]

References

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