

Lack of Medicaid Expansion in Some States

Ejezie Francis Uchechukwu

Department of Social Science, Texas A and M University, Corpus Christi, United States of America

Email address:

ejezief@yahoo.com

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Abstract: The patient protection and Affordable Care Act became law on March 23rd 2010 and was intended to be fully implemented on January 1, 2014. The reason for this law was to address the systemic health inequalities for millions of Americans who lacked health insurance. A major component of this law is the expansion of Medicaid which is the program for the indigent jointly administered by the federal and state government, with the aim of providing low-income individual with access to insurance coverage. Failure of Medicaid to be expanded in most states in the United States is due to some obstacles which have crippled this aim. One of such obstacle is the supreme court decision of June, 2012 nullifying the Affordable Care Act's mandate requiring all states to adopt the Medicaid expansion program. This problem can be tackled by addressing inequalities in social and economic domains as well as the development of a creative expansion program and a user-friendly system.

Keywords: Affordable Care Act, Medicaid, Expansion, States

1. Introduction

The Patient Protection and Affordable Care Act also known as the Affordable Care Act was amended by the Health and Education Reconciliation, and became law on March 23rd 2010. It was intended to be fully implemented on January 1, 2014. At this time, the individual and employer responsibility provisions were to take effect, state health insurance exchanges were to begin operations, Medicaid expansion was to commence and the individual and small-employer group subsidies were to begin flowing (Rosenbaum, 2009). The Patient Protection and Affordable Care act was designed to address systemic health inequalities for millions of Americans who lacked health insurance (Moreno, 2012). As such, when fully implemented, the law was to reduce the number of uninsured people by half, about 94% of Americans were to be insured, the number of people lacking health insurance was to be reduced by 31 million and Medicaid enrollment was to be boosted by 15 million people (Rosenbaum, 2009; Lyon, Douglas and Cooke, 2014). Several aims of this law were to achieve near-universal coverage; improve the fairness, quality and affordability of health insurance coverage; improve health care value, quality and efficiency while reducing wasteful spending, and making health care more accountable to a diverse population;

strengthening primary health care access and bringing long-term changes to primary and preventive health care, and investing in public health (Rosenbaum, 2009). Also, by making health insurance coverage a legal expectation on the part of the US citizens and those legally present in the US, and providing a new affordable insurance market for individuals and families lacking minimum essential coverage, the affordable care act strengthens health insurance coverage reforms (Lyon, Douglas and Cooke, 2014). The importance of the affordable care act cannot be over emphasized. It improves public health and helps in training health professionals, improves health care quality, accountability and efficiency, makes primary health care more accessible and provides long-term care (Shi and Singh, 2015; Rosenbaum, 2009).

Medicaid expansion is a major component of the Patient Protection and Affordable Care Act (Lyon, Douglas and Cooke, 2014; Jacobs and Callaghan, 2013). According to Shi and Singh (2015), Medicaid can be defined as the program for the indigent, jointly administered by the federal and state government. The goal of expanding Medicaid is to enable low-income individuals to have health insurance coverage. By expanding Medicaid, both parents and those without dependent children with income at or below 138% of the federal poverty level were to benefit from the Medicaid

expansion program (Rosenbaum, 2009; Jacobs and Callaghan, 2013; Dorn, 2014). Failure of Medicaid to be expanded in most states in the US is due to some obstacles which have crippled this aim. One of such obstacles is the supreme court decision nullifying the Affordable Care Act's mandate requiring all states to accept Medicaid expansion (Shi and Singh, 2015; Zur, Mojtabai and Li, 2014; Lyon, Douglas and Cooke, 2014; Dorn, 2014; Turner and Roy, 2013). Participation in Medicaid expansion program has advantages and disadvantages. Decrease in number of uninsured people, reduction in mortality rates, an increase in primary health care use and increased rate of self-reported health status are enjoyed by states complying to Medicaid expansion program whereas the disadvantages include harm to the poor, increase in health care spending, access problems will worsen as more Doctors are likely to drop out, private coverage will be crowded and premiums will be raised for those with private insurance (Turner and Roy, 2013). For states not participating in the Medicaid expansion program, the consequences include lack of health insurance for millions of low-income parents and childless adults, insured patients who access health care through safety net will continue to face obstacle to nonemergency care, the number of women without health insurance will be high, and safety net health service providers and hospitals in these states systems that typically serve minorities populations and the poor are likely to suffer from limitations in resources and reduced Hospital payments (Lyon, Douglas and Cooke, 2014).

2. Discussion

Medicaid was created in the year 1965 along with Medicare when the US government for the first time in history, assumed direct responsibility to pay for the health care of two vulnerable population groups. These groups are the elderly and the poor (Shi and Singh, 2015). Before this development, health care could only be paid for by private health insurance which was mainly affordable by middle class working Americans and their families. The elderly, unemployed and the poor could only receive medical care by relying on their own personal resources, inadequate public programs or on charity from individual physicians or hospitals. Sponsoring health care for these groups of people through charity, shifted the difference in cost to private health insurance by raising the rates of individuals covered under private health insurance plans. A process referred to as cost shifting (Shi and Singh, 2015). The elderly, defined as those between the age of 65 and above, and the poor began to be noticed by the government from the 1950s. besides the fact that a significant number of them were incapable of affording their own healthcare due to the exorbitant price, it was discovered that the health status of these special groups of people was worse than the health status of the general population. It was also discovered that they required more sophisticated health care services and when compared to people of younger age groups, the elderly had higher incidence and prevalence of diseases. Also, a very small

fraction of the elderly was able to afford to receive health care through private health insurance (Shi and Singh, 2015).

The year 2010 brought a watershed in the United States health policy (Rosenbaum, 2009). In this year, the Patient Protection and Affordable Care Act was enacted by the United States President, Barack Obama. The law was intended to provide health insurance coverage for majority of United States citizens and those legally present in the United State thereby, significantly reducing the number of uninsured people (Moreno, 2012; Shi and Singh, 2015; Lyon, Douglas and Cooke, 2014; Rosenbaum, 2009). A very important part of this legislation is the expansion of Medicaid, which is the program for the indigent, jointly administered by the federal government and the state governments (Shi and Singh, 2015; Dorn, 2014; Zur, Mojtabai and Li, 2014). The reason behind the refusal of states to adhere to the expansion of Medicaid as mandated by the Patient Protection and Affordable Care act lies in the supreme court ruling on June, 2012 which made it optional for states to expand their Medicaid program. Following this development, many states decided to opt out from the Medicaid expansion program, citing affordability as their primary concern (Zur, Mojtabai and Li, 2014). States such as Texas Louisiana and Florida are examples. Even among the states that adopted the Medicaid expansion program, there are variation in Medicaid adoption. This is due to political party polarization, economic circumstances and institutional capacity of state health policy (Jacobs and Callaghan, 2013). The entire Republican party voted against the Patients Protection and Affordable Care Act whereas almost all the Democrats voted in favor of the act. Partisan control is evident in the fact that states under Republican control are either lacking behind or moving slower in the implementation of Medicaid expansion whereas states with greater Democrats control are moving at a faster pace in the implementation of the Medicaid expansion program. The not so impressive economic circumstances of certain states serve as motivation for implementing the Medicaid expansion program (Jacobs and Callaghan, 2013). States like Washington DC for example which participated in the Medicaid expansion program, covered the cost of expansion for the first three years after which it started receiving 96% of the cost in form of subsidies annually, in addition to the cost and segments of the uninsured population that were previously funded from the state budget thereby, reducing states and local governments' uncompensated care expenses (Jacobs and Callaghan, 2013). Administrative capacity is very effective in boosting the confidence of influential policy makers and politically powerful allies as well as specific effects in empowering government with the tools to build, adopt and implement specific programs. This is evident in states like Oregon and Massachusetts where a strong administrative policy has yielded more effective procedures and resources to enroll Medicaid recipients in managed care which in turn, has produced better results when compared to states with weaker administrative policy (Jacobs and Callaghan, 2013).

Several studies have shown that Medicaid expansion is a

promising first step in improving insurance-related health care disparities (Lyon, Douglas and Cooke, 2014; Krisberg, 2012; Shi and Singh, 2015). This simply means that without national adoption of Medicaid expansion coupled with the variation in income eligibility across states seeking to expand, there will continue to exist, significant coverage gaps in health insurance (Lyon, Douglas and Cooke, 2014). According to Lyon, Douglas and Cooke (2014), expanding Medicaid will significantly increase the availability of providers and health systems to tackle the problem of health disparities. Judging from a financial point of view, the law is a great opportunity that has been offered to states in the United States (Krisberg, 2012; Han et al., 2015). This is evident in the improvements in health outcomes, and the impressive financial assistance offered by the federal government to cover the cost of enrolling new eligible beneficiaries, which is actually 100% of the cost for new eligible beneficiaries for the first three years and thereafter, 90% (Krisberg, 2012). Expanding Medicaid at the state level does not come without challenges (Turner and Roy, 2013; Krisberg, 2012; Zur, Mojtabai and Li, 2014). Revamping how people enroll in Medicaid, high cost of medical care and the negative impact on the finances of the poor are issues that should be addressed before adopting the law (Turner and Roy, 2013). Even so, several studies have proven that the advantages of enrolling in the program by far outweighs the disadvantages (Shi and Singh, 2015; Krisberg, 2012; Turner and Roy, 2013; Lyon Douglas and Cooke, 2014; Zur, Mojtabai and Li, 2014; Rosenbaum, 2009; Moreno, 2012; Dorn, 2014).

The problem of lack of Medicaid expansion in some states does not exist without possible solutions. First, the United States need to address inequalities in social and economic domains that are key to health such as income, education, behavior and environment (Lyon, Douglas and Cooke, 2014). Second, states need to build a consumer-friendly system that can efficiently determine and identify residents' eligibility for Medicaid in real time (Krisberg, 2012). Finally, a creative expansion proposal should be developed by every state to incorporate privatization, personal responsibility and commercial-style benefits, and work effectively with each other and the federal government.

3. Conclusion

The Patient Protection and Affordable Care Act also known as the Affordable Care Act, was enacted by President Barack Obama with the intention of addressing the systemic inequalities of Millions of Americans who lacked health insurance. A major component of this legislation is the expansion of Medicaid, which was made optional by the supreme court ruling of 2012 thereby making many states in the United States including Texas, Florida and Louisiana to opt out of the expansion policy, citing affordability as their major concern (Zur, Mojtabai and Li, 2014). Even among the states that expanded their Medicaid program there exist variation in the degree of expansion due to political polarization, economic circumstances and institutional

capacity of state health policy (Jacobs and Callaghan, 2013). Several studies have proven that states failing to expand their Medicaid program are likely to face negative consequences and the advantages of expanding Medicaid in states by far outweighs the disadvantages (Shi and Singh 2015; Krisberg, 2012; Turner and Roy, 2013; Lyon Douglas and Cooke, 2014; Zur, Mojtabai and Li, 2014). This problem can be put to rest by addressing inequalities in social and economic domains as well as the development of a creative expansion proposal and a user-friendly system.

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