Policy Analysis: The Expansion of Medicaid

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Abstract

This paper analyzes the expansion of Medicaid through the Affordable Care Act. The impact that this expansion has had is reviewed, further examining its effect on varying populations, strengths, and weaknesses. It also assesses how well the policy addresses equality and equity by looking at its level of coverage among varying populations. This assessment explores a flaw in the policy's implementation: the coverage gap, which leaves many Americans without access to affordable health insurance. Furthermore, alternative solutions that address any weaknesses are considered and further reviewed such as universal healthcare and premium tax credits. These solutions take into account where the current policy may be lacking, and recommendations are put forth.

Keywords: Medicaid, Medicaid expansion, Affordable Care Act, healthcare, affordable health insurance

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The Social Problem

Visiting a doctor when one is ill should be an instinctive response, yet in the United States, this is often when the thoughts and fears of unwavering debt occur. One trip to the doctor can become a life-altering decision for many due to resulting financial hardship. A lack of health insurance (or affordable health insurance) is a dilemma that millions face, about 32.8 million under 65 years old to be exact (Centers for Disease Control and Prevention, 2019). In Addition, it is known that racial disparities are extremely prevalent in the United States, and they do not stop at health insurance. The largest uninsured demographics are Hispanic adults at 30.2%, followed by 14.3% of those that are non-Hispanic Black adults. Non-Hispanic white adults have the lowest rates of being uninsured, at 10.2% (Centers for Disease Control and Prevention, 2019). Without health insurance, one is much more likely to face adverse health effects. Henry J. Kaiser Family Foundation (KFF), a credible, non-profit research organization, found evidence of these consequences through their research. An incredibly important aspect of healthcare is preventative care, where one goes for regular checkups and screenings. Those who are uninsured are much more likely to postpone or disregard this type of healthcare, which can leave preventable or chronic conditions to persist without awareness. Reportedly, 42.5% of those uninsured have not seen a healthcare professional in the last 12 months (Tolbert & Orgera, 2020). One crucial reason that preventative care is so important is its ability to avert chronic disease. The United States has some of the highest rates of chronic disease, which can be prevented through access to this type of care. (Levine et al., 2019). Sixty percent of American adults have one chronic disease, and 42% have more than one, with the three most common being heart disease, cancer, and diabetes. These substantial numbers indicate that something in the U.S. healthcare system is not working (Centers for Disease Control and Prevention, 2021).

Compared to 10 other high-income countries, the United States spends the most on healthcare (proportionately to all economic expenses) and has the lowest life expectancy and highest suicide rates. Chronic disease rates also exceed these other countries (The Commonwealth Fund, 2020). Being the top reason for death and disability in the United States, these diseases are often preventable. Without affordable access to healthcare, many have no choice but to forgo their annual visit or screening.

With the many consequences associated with avoiding preventative care, including one's own life, it may seem obvious that the solution is to obtain insurance coverage. The disappointing truth is that this phenomenon is not attainable for many groups in the United States. Of the uninsured, 73.7% of non-elderly adults do not obtain coverage because it is not affordable and 25.3% are not eligible (Tolbert & Orgera, 2020). Low-income families often do not have a choice, even with a worker in the family. Furthermore, 73.2% of those uninsured (non-elderly) have one or more workers in the family (Tolbert & Orgera, 2020), which contradicts the common idea that getting a job will fix one's financial problems. Healthcare policies in the United States are certainly not comprehensive. These policies leave many with the terrifying choice of allowing an illness to take over their lives or falling into debt.

Policy Provisions

One policy that has impacted this issue by decreasing the number of those uninsured is the Patient Protection and Affordable Care Act (ACA). The number of those uninsured in America is now 13.7 million lower than it was in 2010, prior to this policy implementation (KFF, 2019). The ACA has had many implementations, but one specifically is the expansion of Medicaid. Medicaid is the national public insurance plan available to low-income individuals, children, and those with disabilities. It is an entitlement program, meaning all who meet its

criteria are eligible (Center on Budget and Policy Priorities, 2018). Before the expansion of Medicaid, states were required to cover the following populations to receive some governmental funding through Medicaid: children in families below 138% of the federal poverty line (FPL), pregnant women below 138% of the FPL, certain parents/caregivers with extremely low incomes, and some seniors and those with disabilities who received Supplemental Security Income (Center on Budget and Policy Priorities, 2018). Although these vulnerable groups were covered, many others were left without any sort of governmental insurance help, including adults under 138% of the FPL. To put things into financial perspective, 138% of the federal poverty line is $29,974 for a family of three, as of 2020. (Center on Budget and Policy Priorities, 2018). With the implementation of the ACA, Medicaid has been expanded in (now) 39 states, increasing eligibility to all adults who are below 138% of the FPL, not just certain vulnerable populations.

Originally, this expansion was going to be required in all states, but with a supreme court ruling, states can now decide whether they want to expand among themselves. Despite states being able to decide this, all of their Medicaid services remain the same, they just impact different groups of people in states that did expand versus those that did not. Several healthcare services are required to be covered, including physician visits, laboratory services, hospital visits, home health care, and nursing care services (Center on Budget and Policy Priorities, 2018). Although not required, all states' Medicaid services also cover prescriptions, and many cover dental and vision services. As long as one meets the qualifications enlisted by the states they reside in, they will qualify for Medicaid. The delivery of Medicaid is through one of two options (or both), these being: fee-for-service or managed care plans. States receive a majority of funding through the federal government to cover these costs. Looking at these payment models

from a simple perspective, the fee-for-service plan requires states to pay the providers directly for each service received by a Medicaid beneficiary. Used more frequently, the managed care plans work by enrolling Medicaid beneficiaries in a plan, paying a fee to the company running the plan, and then the managed care plan pays the providers for the client's services (MACPAC, n.d.). A majority of those enrolled in Medicaid are in managed care plans, but this type of plan is more limited for higher cost populations, such as older adults and those with disabilities. Because these populations cost more, they are more likely to be enrolled in a fee-for service plan. This is why spending for both plans are fairly similar, even though one plan has the majority of beneficiaries. (MACPAC, n.d.).

Policy Strengths

It is no secret the creation of policies through our legislative system come with many controversies. There will be differing opinions and both pros and cons to any implemented policy. With the expansion of Medicaid through the ACA, the greatest strength was a decrease in the uninsured. Medicaid expansion did not begin until January 1, 2014, with the most specific goal of impacting those who were non-elderly adults. With this, looking at the rates of those uninsured in this population, there is an obvious correlation between the expansion of coverage and a decrease in the uninsured population. Although not all states opted in for the expansion, from the year 2008 to 2013 the approximate percentage of those uninsured was about 17% nationally. In 2014 this went down to 13.5% and has stayed around 10.5% from 2015 to 2019 (Tolbert & Orgera, 2020). Looking a bit more in-depth, one meta-analysis reviewed 77 peer-reviewed studies to identify the effects of Medicaid expansion related to the original goals of the ACA. Of the 90% of studies that analyzed access to care, three-fourths reported an expansion of insurance coverage due to the ACA (Mazurenko et al., 2018).

Another strength that this analysis found relates to the earlier discussed consequence of not being insured: lack of access to primary care. There was an association between an increase in primary, mental health, and preventative care with the expansion of Medicaid (Mazurenko et al., 2018). With continuous findings that those who are uninsured are less likely to obtain preventative care for chronic conditions, finding an increase in these services identifies another key strength that the expansion of Medicaid has brought forth (Tolbert & Orgera, 2020) Studies have even found a decrease in mortality rates overall, and specifically for some chronic conditions (Guth et al., 2020).

Looking at the equity of this policy, another KFF meta-analysis (2020), found that states with expansion saw significant increases in coverage among low-income populations and vulnerable populations (Guth et al., 2020). This analysis by the KFF reviewed and summarized findings from 404 published studies through government, policy, and research organizations from 2014 to 2020. Besides just an increase in coverage, many other strengths of Medicaid's expansion were identified. Continuing to look at the policy regarding equality, a majority of findings identified an improvement in the utilization and affordability of healthcare services, as well as an increase in financial security within low-income populations (Guth et al., 2020). More recent research that the KFF looked at also saw an association between Medicaid expansion and a decrease in poverty, home evictions, and rates of food insecurity (Guth et al., 2020). Due to the high costs of healthcare, it makes sense that those with increased coverage would do better financially. Without coverage, illnesses, both serious and acute can have a substantial effect on one's economic status.

Policy Weaknesses

Although we see these positive outcomes for low-income populations, the weaknesses of this policy must be assessed. Medicaid is a social welfare program; it is providing extra resources for populations in need. Yet, the questions that arise through this policy are: are all in-need populations being covered, and how adequate is this coverage? Looking at the research discussed, it is obvious that the expansion of Medicaid has created a positive impact on the healthcare system, but as also mentioned, every policy has its weaknesses. The strengths previously discussed were based on both national data and data from states that did expand Medicaid. In the states that did not opt-in for Medicaid expansion, there is a very large gap of people who remain uninsured. As of 2019, the average of those uninsured in non-expansion states was 15.5% versus 8.3% in those that did expand (Tolbert & Orgera, 2020). States who did not expand Medicaid can also decide on their eligibility income limits, with the median income limit in these 12 states being only 41% of the poverty line. This is the equivalent of $8,905 annually for a family of three, which is $742.08 a month. This incredibly low monthly income does not even take needed necessities into account, such as rent, groceries, and potential doctor's visits. (Tolbert & Orgera, 2020)

In addition, one's geographic location (their state) is a determinant of whether they will be with or without insurance. Universally, this is not a policy of equality. The policy also fails to consider the differing livable incomes that are dependent on geographic locations. Every state bases its eligibility on the federal poverty line, yet the same annual income in two states could look completely different based on living costs. In the 12 states that have not expanded Medicaid, 2.2 million people are stuck in what is known as the "coverage gap" (Lukens & Sharer, 2021). Before giving states the right to decide if they wanted to expand Medicaid or not,

the policy was supposed to be implemented to all adults up to 138% of the FPL federally. Another federal extension through the ACA was subsidized marketplace coverage, or tax credits for insurance, to those with higher annual earnings. These tax credits reduce monthly insurance expenses for those between 100% and 400% of the FPL (Garfield & Orgera, 2021). These tax credits were applied federally, and the Medicaid expansion was applied by state. Many states cut off Medicaid coverage to incomes of much less than 100% of the FPL, with a median cutoff to those making 41% of the FPL and less. Those making more than their state's FPL cutoff and less than 100% of the FPL are offered no form of Medicaid or discounted insurance rates (Garfield & Orgera, 2021). This is the coverage gap.

To put this into perspective, in some unexpanded states, one childless adult making $12,760 - $51,040 (100% to 400% of the FPL for an individual) annually would be able to get subsidized marketplace to converge. Those making anything less than this are eligible for nothing. This is because they only provide Medicaid for adults younger than 64 years old who have children. (Tolbert & Orega, 2020). An adult with a child would also receive nothing if they annually make more than their state's Medicaid eligibility limit (median of 41% of the FPL for a family of three), but less than 100% of the FPL for a family. Put simply, there is a gap of millions who are not able to afford insurance. They make too much to qualify for Medicaid and too little to qualify for subsidized marketplace coverage in the 12 states that have not expanded (Wisconsin does have an exception because their Medicaid eligibility is for those making up to 100% of the FPL (Lukens & Sharer, 2021).

Although the policy itself is a way to provide more equitable healthcare coverage, its implementation diminishes this. The coverage gap is harming marginalized communities at greater rates than any other group. Within the non-elderly population in non-expansion states,

Black people make up 19% of the population yet 28% of people in the coverage gap. Similarly, Latinx people make up 17% of the population and 28% of the coverage gap (Lukens & Sharer, 2021). Besides this, the ACA did not include undocumented immigrants in either Medicaid or marketplace subsidies. Likely due to this, foreign-born Latinx make up 25% of the uninsured population as of 2018 (Gunja & Collins, 2019). Those who are undocumented must obtain individual marketplace plans, which can be very expensive without any supplemental help. Certain groups being harmed at greater rates by a policy exhibits the inequality it holds, even if only in certain states. As also mentioned, the policy is supposed to provide equitable coverage to reach populations in need due to socioeconomic status. Yet, many still dealing with a lack of any coverage demonstrate its inadequacy.

Policy Recommendations

One policy implementation through President Biden's Build Back Better bill would close the Medicaid gap, reducing these disparities greatly. The bill was passed through the House of Representatives as of November 20, 2021. It would provide people with premium tax credits in states where one makes too much to qualify for Medicaid, but too little to qualify for tax credits federally. Similar to Medicaid, the plan would have no deductibles or copays (Solomon, 2021). This would be the first phase of the plan, beginning in 2022. In the second phase, beginning in 2025, those under the subsidized tax credit plans would transition into an even more Medicaid-like plan. (Solomon, 2021). Additional Medicaid benefits would become applicable in this phase, such as benefits for chronic conditions, both physical and mental, as well as long-term services. This bill would permanently close the coverage gap, which disproportionately affects Black and Latinx populations. Closing this gap would increase the equity and adequacy of this policy (Solomon, 2021). Although not leading to all being insured, this bill would have a

positive health outcome for these populations, especially marginalized groups who already face disparities in the healthcare system.

Another policy, which would equitably cover nearly all people in the United States, would be Medicare for All through Massachusetts Senator Elizabeth Warren's model. This plan displays how reaching full coverage for all in the United States would take a slower implementation process but would eventually transition into a universal healthcare system. When running for president, she discussed this transition as giving everybody the option to stay with their private insurance but offering Medicare freely to children and families making below 200% of the FPL. Additionally, those over 50 years old will be given in improved version of Medicare and those aged 18 to 49 would first be given modest costs for Medicare, which would eventually be free. (Warren, n.d.). The plan would transition into actual Medicare for All, giving every single person health insurance (including dental, vision, long-term care, and more) by taxing large corporations and our top 1%. With this, middle-income taxes would not increase. On her website, Warren provides three expert articles and studies that explain how Medicare for All would provide better quality coverage and cost less for middle-income families. The policy would also cost the country itself just slightly less than what we pay now (Warren, n.d.).

Providing all with insurance would ensure coverage on a basis of equality. Research provides evidence that low socioeconomic status, often associated with marginalized communities, results in worse health outcomes and life expectancies. A universal healthcare policy would not create barriers based on socioeconomic status, provide more accessible care, and mitigate our chronic disease epidemic (Zieff et al., 2020). One peer-reviewed journal article explains that the road to universal coverage may be complicated, but necessary, ensuring better health outcomes, lower chronic disease rates, and increased economic outcomes in the United

States (Zieff et al., 2020). A healthcare policy for all would combat all weaknesses associated with our current expansion of Medicaid, as we wouldn't have millions of Americans unable to access care. This access to care would save Americans from both health and financial hardships. One should not have to choose between a life of debt or a life at all. Through the Patient Protection and Affordable Care Act we have come a long way, but there are still many gaps that must be addressed in order to provide healthcare services to all Americans in an accessible and equitable way.

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