Medicaid Expansion and Access to Healthcare

Christin Brunson, J.D., LL.M. candidate (Health Law)
cdbrunson@central.uh.edu

The Supreme Court’s divided opinion in National Federation of Independent Business v. Sebelius\(^1\) finding that the Medicaid expansion provisions of the Affordable Care Act (ACA) are “unconstitutionally coercive” on the states was a great loss for ACA supporters. With a key provision of the ACA invalidated, states now hold the reigns as to whether Medicaid expansion will take effect within their borders. This affects access to care for millions who are left in the middle, most notably the working poor, who fail to qualify for Medicaid while also failing to qualify for federal subsidies.

The Supreme Court ruled that the provision in the ACA that called for states to expand Medicaid was “unconstitutionally coercive.”\(^2\) Before invalidation, the goal of Medicaid expansion was to provide access to coverage for poorer individuals and families, with the working poor heavily falling into this category. Medicaid expansion under the ACA is the key to insuring that these individuals have access to healthcare coverage, and therefore adequate access to health care in general. As written, states were required to expand Medicaid coverage to include eligible nonelderly adults with incomes less than 138 percent of the federal poverty level or risk losing federal funding for their state’s Medicaid program.\(^3\) However, in the process of invalidating Medicaid expansion, the Court restricted the enforcement power of the Secretary of Health and Human Services leaving

---

\(^2\) Id. at 2630.
Medicaid expansion in tact but severely limiting the federal government’s power to enforce expansion. Consequently, states could now opt-out of Medicaid expansion with no penalty.

In states that have chosen to expand Medicaid, the federal government will fully fund the expansion to cover those who are now newly eligible for coverage until 2016 with the federal government limiting funding to 95% in 2017 and then to 90% by 2020. According to the American Academy of Family Physicians (AAFP), “[t]he additional cost of implementing the Medicaid expansion is estimated to be only a 2.8 percent increase from what states would have spent between 2014 and 2022 without the health law reform.” Further, the AAFP goes on to suggest that the calculated 2.8 percent is “…significantly overstated, as [the Congressional Budget Office’s] calculations do not factor in the savings that state and local governments will realize in their health care spending for the uninsured.” Therefore, how can some states justify leaving such a large sum of money on the table? In rejecting Medicaid expansion, many states have argued that the cost of implementing Medicaid expansion would severely burden their states financially.

If expanding coverage will lower the cost of uncompensated care because uninsured individuals who could now qualify for Medicaid would be required to enroll for coverage, then how can states justify turning down such a large sum of money? Many states argue that expanding Medicaid will eventually bankrupt the state, including Governor Bryant of Mississippi. However, the evidence of this seems to be lacking according to some critics. In fact, some economists believe that not only will Medicaid expansion lower the cost of uncompensated care but most states will also experience budget gains in the future. According to the Center for Mississippi Health Policy, “[t]he annual gross state Medicaid costs for expansion would range from approximately $8.5 million in

---

6 Id.
7 Id. (The Urban Institute predicts that states will save between $26 and $52 million with the Lewin Group’s predicting a significantly higher number, $101 billion in savings, for uncompensated care).
2014 to $159 million in 2025. Over the same period of time, the federal dollars flowing into the state for Medicaid Expansion would range from an estimated annual amount of $426 million in 2014 to $1.2 billion in 2025.” The article goes on to state, “[t]he economic activity associated with the influx of federal dollars contributes to employment additions in the state that range from 4,178 jobs in 2014 to 8,860 jobs in 2025. The new jobs contribute additional revenue for the State General Fund which offsets some of the state costs for expansion.” Therefore, this policy has the potential of generating enough business around health care access that the money coming into the state from expansion will exceed the cost.

In those states that have decided not to expand Medicaid coverage, such as Mississippi, the likely effects will be daunting. The stories of people in dire need of health coverage who make too much to qualify for Medicaid and are too poor to qualify for a federal subsidy are heart-wrenching across states that have decided not to expand Medicaid. Interestingly, this is the very group that is in need of coverage and poses the highest burden on the healthcare industry. Ted Carter highlights Dr. Steven L. Demetropoulos’s, an ER physician and Mississippi State Medical Association 2012-2013 president, stance in the April MSMA Journal stating “…emergency rooms around the state serve as a primary health care source for many of the working poor who would be covered under Medicaid expansion. Keeping low-income workers off the Medicaid rolls and forcing them to rely on emergency rooms and federally funded free clinics around the state will put tremendous financial stress on the state’s entire health system.”

Another source of stress resulting from the Medicaid expansion debate is the loss of federal disproportionate share payments. Regardless of whether a state has decided to expand Medicaid or not, the federal government still has leverage going forward. Because Medicaid expansion was

---


designed to provide coverage for low-income uninsured individuals there in turn would no longer be a need for disproportionate share hospital (DSH) payments.

DSH payments are made to hospitals by the federal government as a means to reimburse hospitals that see a large number of uninsured patients for uncompensated care. In areas where DSH payments make up a significant portion of a hospital’s revenues, a lack of reimbursement for providing care to uninsured individuals will be the determining factor as to whether the hospital continues to profit. According to the Mississippi Business Journal, “[h]ospital administrators have said reducing the payments would hurt their finances and some have used that as an argument to support expansion of Medicaid…”¹⁰ In rural areas, such as Mississippi, DSH payments from the federal government are their saving grace. Without these payments rural hospitals could go bankrupt and cease to operate, effectively shutting down some of the largest employers in these smaller areas and thereby severely limiting access to care. Consequently, withholding DSH payments from hospitals could be a powerful tool the U.S. Secretary of Health and Human Services has to guide states, such as Mississippi, toward expansion. If the Department of Health and Human Services is serious about getting states on board to expand Medicaid terminating DSH payments, which has been delayed until 2015, is a valuable tool the Department could utilize in guiding non-expansion states toward expansion.

Mississippi is one of the nation’s poorest and unhealthiest states topping the charts in poverty, obesity, diabetes, and heart disease making it ideal for Medicaid expansion. According to Julie Steenhuysen’s article “Mississippi blues: The cost of rejecting Medicaid expansion,” citing Ed Sivak, Director of the Mississippi Economic Policy Center, “[i]n Mississippi, a two-parent working family of four earning $10,000 to $23,500 would not be eligible for assistance either through

Medicaid or the exchange because the state did not expand Medicaid.”

Situations such as the one cited provide a grim look into the lives of those who will most be effected by a state’s refusal to expand Medicaid. Willie Carter, a 53-year-old male and Mississippi resident, was most recently employed as a maintenance worker at one of the local public schools. Although Mr. Carter’s income is below the Medicaid ceiling he does not qualify for aid in Mississippi because he has no dependents. Having problems with his leg since his last surgery and fearing the closure of the local clinic he visits to receive medical care, Mr. Carter states, “I’m scared all the time, … I just walk around here with faith in God to take care of me.”

If the federal government is willing to fund Medicaid expansion initially and people are in dire need of health care access, how can we justify allowing people like Mr. Carter to fall through the cracks?

Many Southern governors feared that running their own state exchanges would eventually lead to Medicaid expansion and therefore refused to create state run exchanges for their residents. Mississippi, interestingly, was the only state to apply to run its own exchanges and to be turned down by the federal government due to concerns that Mississippi Governor Phil Bryant would not support the launch, although Mississippi Insurance Commissioner Chaney submitted an exchange proposal to the Department of Health and Human Services. In a dramatic tale of tug of war between Mississippi’s Republican Governor and Republican Insurance Commissioner a fight ensued over which of the two had the authority to formulate an exchange plan to be submitted to the federal government for approval. Bryant, along with many other Southern governors, vehemently opposed the ACA urging Health and Human Services Secretary Kathleen Sebelius to block Commissioner Chaney’s proposal stating that “…only the governor—not the insurance commissioner—has the

---

12 Id.
13 Id.
14 Id.
authority to act on behalf of the state.”15 Bryant, along with arguing that Chaney lacked authority to create the exchange, feared that the creation of an exchange would ultimately lead to Medicaid expansion, a key component of the ACA.

Although Commissioner Chaney also opposes the ACA, he believed that a state-run exchange rather than a federally run exchange would better benefit Mississippians, an idea that was not new to Mississippi.16 Under the leadership of Former Governor Haley Barbour, Republicans were initially on board to create a state run exchange as a way to provide Mississippians with a marketplace to shop for affordable health care coverage.17 Therefore, Commissioner Chaney argued that he had statutory authority to create the Mississippi exchange, despite the Governor’s opposition.18

As tensions mounted between the two, U.S. Secretary of Health and Human Services, Sebelius, ultimately rejected Mississippi’s plan citing the discord between Governor Bryant and Commissioner Chaney as one of the deciding factors. Therefore, in an effort to defeat Medicaid expansion, Governor Bryant successfully blocked federal approval of a Mississippi state run exchange, created in the hopes of providing Mississippians better access to health care coverage.

If certain states fear the consequences of Medicaid expansion, then perhaps an alternate solution should be discussed amongst its lawmakers. For example, Arkansas’s Democratic governor, Mike Beebe, proposed an alternate expansion model because the Republican controlled legislature refused to expand Medicaid. According to Steven Ross Johnson, “…CMS granted Arkansas a Medicaid Section 1115 waiver that allows the state to move forward on its plan to use federal funding available under the Patient Protection and Affordable Care Act to buy private health plans to provide coverage for…”

---

17 Id.
18 Id.
coverage through the state’s new insurance exchange in 2014 for adults with incomes up to 138% of the federal poverty level.”19 Beebe was quoted saying, “[i]nstead of rallying against the federal government, we found a way to work within the system.”20 If reducing the cost of uncompensated care is a concern for all states, then more effort should be made on the part of non-expansion states to find creative ways, such as the Arkansas solution, to provide coverage for their low-income working residents.

Regardless of whether one agrees that the ACA is constitutional or not, it is now federal law. Therefore, how can one rationalize leaving a large group of low-income uninsured individuals behind? Healthcare costs will be subsidized in some manner whether by increasing the cost of administering care, or increasing the costs of health insurance premiums. If health insurance coverage is one of the best means to provide Americans with access to affordable healthcare, then states should make an effort to ensure their residents have access to adequate coverage whether that is through Medicaid expansion or creating an alternate proposal, such as Arkansas.

---


20 Id.