Deficit or Surplus : State Medicaid Expansion under the Affordable Care Act

Introduction

In June, 2012, the Supreme Court of the United States ruled that the Patient Protection and Affordable Care Act (the ACA) is constitutional under the laws of the United States, however, states could not be forced into accepting the provisions of the Act that included expanding the Medicaid program as was intended by the Act. Originally, the Act stipulated that states that did not accept the expansion would forfeit their participation in the Medicaid program altogether. Following this decision, there has been a national debate about whether or not it is beneficial to opt into the Medicaid expansion on a state level. The debate has been both partisan and financial, with 27 states (including Washington DC) implementing the expansion in 2014, 5 states still debating whether or not they should implement the expansion, and 19 states rejecting the expansion (The Henry J. Kaiser Family Foundation, Status of State Action on the Medicaid Expansion Decision, 2014). This paper will explore whether or not it makes financial sense for a state to accept the Medicaid expansion, and what negative impact there could be if states do not accept the expansion.

Medicaid, Before and After

Until the ACA was passed, the several states had different requirements to become eligible for Medicaid benefits. This created a problem where people who had high enough earnings to not qualify for Medicaid would not make enough money to be able to easily afford their own private insurance plan. Under the new law, individuals are eligible for Medicaid coverage if they earn up to 138% of the Federal Poverty Level (FPL), which in 2014 dollars is $21,707 for a single individual or $32,913 for a family of four (Medicaid.gov, Poverty

Guidelines). Individuals falling into this category will be covered by Medicaid, which includes the federal government paying 100% of health care costs through 2016, and trickling down to a final 90% by 2020. Prior the ACA, Medicaid coverage was only available for children, pregnant women, low-income parents, the elderly, the blind, and the disabled. States were given discretion to adjust the income criteria for these categories of individuals which results in some variance between states concerning who is eligible and who is not (National Association of State Mental Health Program Directors, Transformative Impacts of Medicaid Expansion on States).

Under the previous Medicaid model, there was a combination of benefits required by the federal government and optional for the state to include in their Medicaid coverage. The federal government required physician services, hospital services, family planning services, health center services, and nursing facility services as a component of health plans. Alternatively, atates were permitted to include dental care, mental health care, eye glasses and vision care, coverage for prescription drugs, home health care, case management, and rehabilitation services. Now, states are required to provide certain "Essential Benefits" to Medicaid plan beneficiaries that greatly overshadow the previous benefits offered by the state and federal governments. These Essential Benefits include: ambulatory patient services , emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services, including oral and vision care. (National Association of State Mental Health Program Directors, Transformative Impacts of Medicaid Expansion on States). These benefits apply to all health plans that will be sold in states that accept the Medicaid expansion, which means that they will also apply to insurance sold by private third-party insurers. The parity between the Medicaid

benefits and benefits that could be obtained through private insurance will ensure that Medicaid beneficiaries are receiving the same quality and range of care that other, wealthier, individuals are.

One of the primary goals for the ACA is to *reduce* the number of uninsured individuals in the United States. Under the old Medicaid framework, the cost of treating uninsured individuals usually fell on the hospitals that treated them, because they would not be reimbursed by the state or federal governments. Treating uninsured individuals and not receiving payment is budgeted under "charity care" and "bad debts" in a hospital's finances. This situation was created by statutes such as the Emergency Medical Treatment and Labor Act, 42 U.S.C. 1395dd (EMTALA), which require hospitals to provide emergency health care treatment to anyone who comes to them, regardless of citizenship or ability to pay (CMS.gov, Emergency Medical Treatment and Labor Act). While the workings of EMTALA will undoubtedly create a social good, it places an undue burden on hospitals that repeatedly treat uninsured individuals who cannot pay for the medical care they are receiving. The ACA attempts to fix this by guaranteeing coverage for low-income individuals under Medicaid, which results in the federal government paying 90-100% of the cost to treat them under the new Medicaid framework. The National Association of State Mental Health Program Directors predicts that the ACA will reduce spending on uncompensated care by 50%, which translates to significant revenue gains for hospitals by the elimination of bad debt and a reduction in compulsory charity care (Transformative Impacts of Medicaid Expansion on States). The money to pay for this care has been diverted from specialty "Disproportionate Share Hospitals," (DSH) which have historically treated indigent and urban populations in concentrated areas (Robert Wood Johnson Foundation, Urban Institute, The Financial Benefit to Hospitals from State Expansion of Medicaid). Funding

for DSH has been reduced by $56 Billion from 2013-2022, and Medicaid fee-for-service payments have been reduced by $260 Billion. This represents the federal government covering care for the same group of individuals under the new Medicaid plan at regular hospitals, which will result in the hospitals actually getting reimbursed for the work that they are doing. In states that do not accept the Medicaid expansion, hospitals will still be forced to treat low-income populations without getting reimbursed under the existing EMTALA framework. In states that accept the Medicaid expansion, there should be a remarkable reduction in the number of uninsured individuals. The reduction in the number of uninsured individuals will be a combination of newly-eligible Medicaid enrollees, as well as previously-uninsured people who will purchase insurance through either a state exchange or a third-party insurer as a result of the individual mandate. This will result in revenue increases from hospitals as Medicaid payments from the federal government as well as reimbursements from third-party insurers pour in. To illustrate this point, in 2006 when Massachusetts engaged in health reform to reduce the number of uninsured, uncompensated care payments to hospitals were reduced by 40% in the first year (The Financial Benefit to Hospitals from State Expansion of Medicaid).

Impact on Hospitals

While the number of uninsured individuals drops in states that accept the Medicaid expansion, it is expected that a number of people will move from private insurance plans to government-subsidized Medicaid plans. This will result in a reduction in private insurer hospital payments, but should not result in an overall reduction in hospital revenue. Private payments to hospitals are on average 38% higher than payments from Medicaid, however, hospitals will be dealing with an influx of new patients as a result of the Medicaid expansion which will help offset the reduction in payment amounts. Hospitals will receive a greater number of smaller

payments instead of a smaller number of greater payments. The Robert Wood Johnson Foundation has found that this will lead to an overall increase in hospital revenue, and predicts that for each $1.00 that the ACA eliminates in private insurer revenue, hospitals will receive $2.59 in additional Medicaid revenue. (The Financial Benefit to Hospitals from State Expansion of Medicaid). According to the Robert Wood Johnson Foundation, if all 50 states adopted the Medicaid expansion, hospitals would receive $293.9 Billion in additional revenue from 2013-2022, as opposed to a mere $47.3 Billion that hospitals would receive if the Medicaid expansion did not take place at all. This underscores the importance of the states working together to expand Medicaid across the entire United States, and it also illuminates the failure of the Supreme Court in allowing some states to opt in while others reject the plan. In a sense, one state's rejection of the Medicaid expansion will cost every other state that *does* opt in a significant portion of the revenue that they *should be* receiving under the ACA's framework. This permits partisan politics in one state to affect the health care options and outcomes that are available to citizens in every state.

In states that have rejected the Medicaid expansion, legislators have placed a huge burden on hospitals to treat large populations of uninsured patients without matching federal reimbursement under the previous DSH framework. This is likely to have an adverse impact on hospital budgets, and could very well result in some hospitals being forced to close their doors because they cannot recoup those losses without charging supracompetitive pricing in the open market. This could lead to healthcare antitrust issues, as hospitals might be forced to merge in order to survive. Hospitals are our national defense against sickness and disease, and it is extremely important for them to remain both open and competitive. To do otherwise would

doom state populations who would not have adequate access to competent health care facilities and professionals.

Impact on the States

In addition to improving hospital budgets, the Medicaid expansion will also have a great impact on how states treat mental health and substance-abuse problems. Under the old Medicaid plan, states paid the majority of the bill when it comes to mental health and substance abuse, contributing on average more than 40% for the treatment of these problems. In a state that accepts the Medicaid expansion, this burden is shifted from the state government to the federal government, as uninsured persons earning up to 138% of the FPL will receive their care subsidized by Medicaid instead of through the state, as mental health services, substance abuse treatment, and rehabilitation services are all covered under Medicaid as Essential Benefits. Even those individuals who were previously uninsured and who will receive new coverage through state insurance exchanges will benefit from these services because the Essential Benefits extend to private insurance plans as well. According to the National Association of State Mental Health Program Directors, 79% of individuals who are treated by state mental health agencies are either unemployed, while 43% of them are ineligible for Medicaid coverage. With the ACA reaching full implementation, the number of people with mental health or substance abuse issues who are covered by Medicaid is expected to rise from 12.4% to 23.3%. This is expected to result in a net gain for all of the states of $40 Billion from 2014-2019 because the cost burden will be shifted from the state governments to the federal government (Transformative Impacts of Medicaid Expansion on States). In some long-term care situations focused on mental health and substance abuse, state spending will shift from 100% to a mere 10% as a result of federal Medicaid reimbursements for newly-eligible Medicaid enrollees.

If all states expanded the Medicaid program under the ACA, state Medicaid spending is expected to increase by a mere 3% between 2013-2022 ($76 Billion), while federal Medicaid spending is expected to increase by 26% ($952 Billion). State spending figures will vary by state, as revenue gains made by newly-eligible Medicaid populations will offset increased expenditures, and states can mitigate the expenditures by a variety of methods left to the individual legislatures. Additionally, increased federal Medicaid spending will equate to revenue gains by both state agencies and hospitals receiving new Medicaid patients and the revenue stream that comes with them (Transformative Impacts of Medicaid Expansion on States). A reduction in state spending on mental health and substance abuse treatment is simply one way in which the ACA will improve state revenues as a result of the Medicaid expansion. Additional revenue will be made by the states downstream as states that accepted the Medicaid expansion will attract investors from other states and medical professionals who will prefer to practice in a Medicaid-expanded jurisdiction as opposed to one that rejected the expansion. The National Association of State Mental Health Program Directors outlines seven ways that state economies will see gains as a result of the Medicaid expansion: 1. Increasing State Revenue from Taxes on Health Insurance Premiums; 2. Increasing Federal Dollars on Behalf of New Enrollees Affecting Providers; 3. Creating New Jobs Associated with Providers Delivering Care and Other Services; 4. Increasing Income Associated with Delivering Care and Services; 5. Increasing Purchases Associated with Carrying Out Health Care Services; 6. Flowing or Influx of New Federal Dollars Benefitting Other Businesses and Industries Directly; and 7. Inducing Changes in Household Consumption and Tax Collection (Transformative Impacts of Medicaid Expansion on States).

Conclusion

It is easy to under- or over-state the theoretical gains that can be made by the states, where *actual* gains have yet to be seen. However, in the coming years the intent and efficacy of the ACA will shine, especially in states that have accepted the Medicaid expansion. Hopefully this will coerce the more conservative state legislatures to approve the Medicaid expansion, leading to their hospitals flourishing in the new health care economy, and state revenue increasing from increased Medicaid payments received from the federal government.

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