**MEDICAID IN AMERICA**

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**ABSTRACT**

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Medicaid covers around sixty-six million Americans in the United States. Medicaid connects many people to healthcare benefits while limiting out-of-pocket costs. Public health insurance options have been a source of contention throughout U.S. history and have limited Medicaid’s scope in coverage. Due to limitations of Medicaid and varying state-by-state regulations, forty-seven million non-elderly individuals remain uninsured. The high cost of insurance has deterred many from receiving coverage, and many individuals receive imperfect information regarding market costs, thus making it difficult to negotiate prices in the private health insurance marketplace. Many of these uninsured individuals are working, but make too much to qualify for Medicaid. In recent months, Pennsylvania has undergone many changes in health reform. After opting out of the Patient Protection and Affordable Care Act’s Medicaid Expansion, Governor Corbett implemented his own proposal, *Healthy Pennsylvania,* to reduce the number of uninsured individuals in the commonwealth. Using federal funds as subsidies for individuals to purchase private health insurance plans, approximately six hundred thousand more individuals will be covered under the plan approved by the Centers for Medicare and Medicaid Services (CMS).

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# Introduction

Throughout the course of United States history, the government has failed to play a key role in the nation’s health and welfare systems. Before Medicaid was signed into law in 1965, national welfare programs were considered unconstitutional and most social welfare programs were solely at the local level. Indigent people were often left to rely on local governments to provide poor-quality care at public clinics, hospitals as well as almshouses. Many Americans in the nineteenth century United States received care in their homes, often from a multitude of charlatans, paying out-of-pocket-fees or receiving care in exchange for various commodities (Kovner & Knickman (Eds.), 2011, p. 29). When allopathic physicians became the only licensed medical providers at the end of the nineteenth century, hospitals became more legitimized and grew to be profitable institutions. At this time medical technology improved and urbanization and industrialization flourished. As social stigmas around hospitals decreased, the wealthy began to dominate hospital usage. Costs have always been correlational with industrial growth, thus the wealthy were the only individuals able to afford quality care from this new cadre of physicians (Kovner & Knickman (Eds.), 2011, p. 30).

**Objective:** The aims of this study are to explore the background associated with Medicaid of the Patient Protection and Affordable Care Act, as well as to explore the array of perspectives and interests that have influenced their implementation decisions over time. In addition, the aim is to recommend policy practices that should be considered for implementation alongside or in place of *Healthy Pennsylvania* in order for health access barriers to be removed and quality of care to be improved in Pennsylvania’s population.

**Method:** This analysis utilizes data from books, selected articles, and public health agencies.

**Results:** Despite current laws in place to protect the rights of patients in regards to access to quality care, interest groups as well as staunch opponents of the Affordable Care Act have manipulated public opinion in order for provisions to be added or removed in their favor. It is via media outlets, as well as the language used in the ACA, that this law has been tailored in order for (most) states to remain in control of the regulation of private insurance companies. Despite the increase in the number of previously uninsured that will now become insured, the individuals left in the “gap” remain uncovered and therefore without access to medical care coverage.

**Conclusion:** Federal agencies and advocate groups should continue to collaborate to eliminate the barriers that limit vulnerable populations from accessing quality healthcare delivery systems. This is especially pertinent for the working populations, where many of these individuals make too much to qualify for Medicaid. Shaping public opinion should be a priority regarding the true issue at hand: the number of uninsured needs to be reduced and access to quality care should be guaranteed.

## A History of Medicaid in the united states

During World War II, employers were exempt from mandatory coverage of employees and in the 1950s, employers were no longer forced to pay employee premiums as part of employee salary (Kovner & Knickman (Eds.), 2011, p. 29). During the mid-1950s, one of the only options Americans had to be covered for care was to purchase private insurance plans. The most vulnerable populations were unable to afford private plans and thus lacked access to medical coverage. These populations, similar to today, included the elderly, persons with disabilities, those who were self-employed, those who worked part-time jobs, and employees of small businesses (Kovner & Knickman (Eds.), 2011, p. 29). Talk of universal coverage existed, however was staunchly opposed by conservatives who did not believe free coverage should be given to those who were neither poor nor particularly needy (Kovner & Knickman (Eds.), 2011, p. 29). In 1950 the Social Security Act was amended so that federal funds could be provided to states to be used toward paying health care providers and cover medical care for welfare recipients (Kovner & Knickman (Eds.), 2011, p. 30). Because the responsibility was passed from the federal government to the states, the amendment received bi-partisan support. In 1960, President John F. Kennedy expanded this “welfare medicine program,” known as the Kerr-Mills Program, to cover the elderly as well as persons with disabilities (Kovner & Knickman (Eds.), 2011, p. 30). However, it wasn’t until 1965 that a Democratic President as well as a Democratic House took advantage of their window of opportunity to enact change. President Lyndon B. Johnson envisioned the creation of a “Great Society” where three initiatives became law: hospital insurance for the elderly (Medicare Part A), physician insurance for the elderly (Medicare Part B), and the expansion of the Kerr-Mills Program, which would become Medicaid (Kovner & Knickman (Eds.), 2011, p. 30).

Medicaid is an entitlement program that is state-administered and provides health insurance to low-income state residents. States vary in terms of eligibility rules, benefits provided, as well as payment schedules. They are responsible for regulating policies; determining the type, amount, duration and scope of services; setting payment rates, and the administration of each program (Kaiser Family Foundation, Medicaid moving forward, 2014). The federal government provides fifty to seventy-eight percent of Medicaid costs to states depending on state per capita income (Department of Health and Human Services, 2012). As of 1990, it was required that pregnant women, children under the age of nineteen and families whose income was below one hundred percent of the federal poverty level be covered (Department of Health and Human Services, 2012). As more people began to qualify for Medicaid, the cost of the program rose dramatically growing from $57.5 billion in 1988 to $157.3 billion in 1995 (Department of Health and Human Services, 2012). During the Clinton administration, Hilary Clinton tried and failed at implementing a universal healthcare system. Many states objected this proposal and insisted that federal Medicaid mandates be lessened. Thus states were given more autonomy and flexibility when it came down to federal Medicaid rules and regulations (Department of Health and Human Services, 2012). More states began to encourage or even require that Medicaid recipients enroll in managed care systems furthering disparities in access, and by 1998 over twenty million recipients partook in these systems (Department of Health and Human Services, 2012). In the early 1990s, states showed a decline in the number of Medicaid enrollees. This was due to the fact that millions did not know their eligibility status due to a lack of familiarity with insurance markets. States also set steep administrative hurdles, such as increasing enrollee paperwork as well as increasing how often enrollees were required to prove their eligibility, that left individuals who were eligible feeling stigmatized and discouraged from enrolling (Department of Health and Human Services, 2012).

Medicaid expenditures have continued to increase due to several factors. Prescription drugs are now more expensive, services for people with disabilities have widened in range, and long-term care prices have skyrocketed (Department of Health and Human Services, 2012). Federal mandates, population growth, economic recessions, and the increase in eligible persons among vulnerable populations have all contributed to growing costs. Utilization has increased since more individuals are eligible to be covered. Many hospitals are required to cover and provide inpatient services to a disproportionate number of Medicaid beneficiaries. States must therefore pay additional payments to these hospitals. These payments are termed the “disproportionate share hospital adjustment” (DSH) (Longest, 2010, p. 233). Inappropriate use of the DSH adjustment results in higher expenditure rates and increases the amount of federal payments made to states. The U.S. population has shifted and has increased in the number of elderly individuals as well as persons with disabilities. Both of these populations are covered under Medicaid. These populations especially require extensive long-term care and various services that amount to more money being spent. Advancements in technology have helped society and the American population to thrive, however, they have also enabled costly revolutionary treatments to extend the lives of those who are severely and critically ill as well as better the chances of survival of low-birth weight and premature infants (Department of Health and Human Services, 2012). Payment rates to providers have also increased to incentivize more hospitals in the program’s participation.

Economically, the 2000s showed to be years of rapid growth but also steep financial decline. One way to cut high costs was to restrict what Medicaid offered. This was done in some states by freezing or cutting provider reimbursement, limiting access to prescriptions, reducing benefits, narrowing eligibility restrictions, increasing co-payments, and expanding disease management initiatives (Department of Health and Human Services, 2012). It had been intended in the 1990s for more resources to be put forth toward educating the public about their state specific Medicaid programs. However, when the financial crisis hit the United States in 2008, there was no room in the budget for this to occur (Kaiser Family Foundation, Medicaid moving forward, 2014).

Medicaid costs are a joint responsibility between states and the federal government. Thus, states can pay medical providers directly via fee-for-services, or through a variety of prepayment arrangements such as health maintenance organizations (HMOs) (Kaiser Family Foundation, Medicaid moving forward, 2014). The amount of money that states receive from the federal government is determined by state per capita income. The states with a higher per capita income receive less money from the federal government. States vary in payment methods but broadly they must all enroll enough medical providers so that Medicaid recipients can theoretically receive the same services that non-Medicaid recipients receive in the same geographic area (Kaiser Family Foundation, Medicaid moving forward, 2014). Certain services allow for states to establish nominal deductibles, coinsurance, or copayments for some Medicaid recipients (Kaiser Family Foundation, Medicaid moving forward, 2014). However, there are exceptions to these regulations including pregnant women, children under eighteen, and hospital or home patients paying the majority of their income toward institutional payments, all of whom are exempt (Longest, 2010, p. 235). All Medicaid recipients are exempt from copayments for emergency services as well as family planning services. There are certain programs as well as payments that have no set limits. In these programs payments made from the federal government to the states match state expenditures. These include payments for mandatory services, administrative costs, and optional services that vary by state (Longest, 2010, p. 233). As costs have continued to increase, a solution was needed in order to insure more individuals and to create a more cost-effective delivery system.

## the groundbreaking solution: the patient protection and affordable care act

Currently, around sixteen percent of the nation’s population is uninsured accounting for almost fifty-one million individuals (Kaiser Family Foundation, Medicaid moving forward, 2014). Most of these individuals have families and are working, however, they may make too much to qualify for Medicaid. This gap in coverage refers to around 4.8 million individuals and occurs in twenty-three states; the majority are uninsured poor adults forced to remain in states that chose not expand Medicaid (Kaiser Family Foundation, Medicaid moving forward, 2014). They may also be self-employed or working for small businesses. The decline in the number of insured individuals began in the 1990s and escalated in the 2000s during the economic financial crisis (Kaiser Family Foundation, Medicaid moving forward, 2014). One of the main reasons for the decline was the fact that many employers were not offering health benefits as part of employee salary. Many employers stopped sponsoring coverage for their employees due to the fact that they were required to pay a large share of the medical bills that employees needed to pay (Kaiser Family Foundation, Medicaid moving forward, 2014). Many employers also hired many part-time employees versus full-time employees so that mandated employee-covered health insurance plans could be circumvented. Talk of mandates ensued where the federal government tried to implement employer-sponsored health insurance. However, these plans were terminated by business owners who argued that mandates would be too costly as well as force many employers to eliminate job opportunities in order to cover employee health insurance (Kovner & Knickman (Eds.), 2011, p. 32).

There are three main structural problems with Medicaid that still exist today:

1) Employers of small business often are unable to afford and provide private health plans to their employees. They also do not know enough about the market to negotiate good deals and commonly associate insuring small groups of individuals with high administrative costs.

2) Individuals who are self-employed or who work for small businesses ordinarily earn too little to purchase private health plans in the individual market.

3) Individuals who are deemed “high risk” with catastrophic medical costs are often excluded from private markets regardless of their ability to pay.

(Kovner & Knickman (Eds.), 2011, p. 35-36)

Until these structural problems are addressed, many uninsured individuals will be left to use emergency room services when they are in dire circumstances, leaving local hospitals forced to absorb these costs.

In 2010 a window of opportunity opened for Democrats to promote public insurance programs. President Obama took office with the goal of significantly reducing the number of uninsured individuals as well as to slow the cost of health care while creating a more efficient delivery system (Kaiser Family Foundation, Medicaid moving forward, 2014). However, interest groups and opponents tried to convince the nation’s public that public insurance is a “socialistic” idea of medicine that would be bad for the nation’s health. Conservatives and other opponents argued that people should be responsible for paying for their own care rather than covering “invisible” individuals who may or may not have a wide array of health problems. Even so, the President prevailed and passed the Patient Protection and Affordable Care Act of 2010 (ACA) with the intention of covering thirty-two million more uninsured Americans and with five primary initiatives in mind:

1) Under Federal law all Americans are now required to have some form of health insurance or they will be subjected to a penalty tax.

2) Medicaid has been expanded to cover all individuals with incomes below one-hundred and thirty-three percent of the federal poverty level covering between sixteen to eighteen million additional individuals.

3) Insurance exchanges have been created in each state in order for symmetric information regarding the market to be made available to the general public. The federal government provides subsidies to persons with incomes up to four hundred percent of the federal poverty level to help them afford more reasonable coverage.

4) All employers with over fifty employees must provide coverage or be subjected to a financial penalty that will be paid to the federal government.

5) Finally, private insurance companies are forced to offer and no longer discriminate against persons with pre-existing conditions or those deemed to be “high-risk.”

(Kovner & Knickman (Eds.), 2011, p. 36-37)

The Affordable Care Act passed in March of 2010 and expanded both who qualified for Medicaid benefits as well as the program’s funding. Medicaid Expansion, as proposed by the ACA, makes all adults between the ages of nineteen to sixty-four with incomes at or below 138% of the federal poverty level (FPL) eligible for the program (Kaiser Family Foundation, Medicaid moving forward, 2014). This expansion covers vulnerable persons as well as healthy, able-bodied individuals. It was designed to increase access to affordable health insurance and to provide for the creation of health insurance exchanges. It also offers qualified health plans, as well as advanced payment of premium tax credits to individuals with incomes between 100% and 400% of the federal poverty level (Greenhalgh, 2013). Now any individual who earns up to 138% of the Federal Poverty Level qualifies, thus including individuals making up to $15,900 a year as well as families of four making $32,400 a year (Kaiser Family Foundation, Medicaid moving forward, 2014). Being covered by Medicaid protects more individuals’ financial health as well as their physical health. One hundred percent of the expansion costs are federally funded until 2016, and will total $43.3 billion in new federal funds for Pennsylvania when Pennsylvania expands the Medicaid program in January. Ultimately it allows for 600,000-800,000 individuals to become covered and cuts the uninsured rate by 52% (Greenhalgh, 2013). On a national level it allows for 17 million more Americans to be have medical coverage.

In June of 2012 the Supreme Court ruled that Medicaid Expansion was unconstitutional and that states could not be forced to expand Medicaid. This decision was based on the belief that states were not given enough notice to voluntarily consent and the Secretary could potentially punish states by withholding all of a state’s existing federal Medicaid funds if they did not comply with the rules they were given (Greenhalgh, 2013).

### The Government as a Regulator

The government’s role as a regulator of private insurance companies has dominated health politics for many years. Differing opinions between parties regarding health reform can be a source of contention for Congress as well as the President. Before the ACA, the government had exercised little oversight over the health insurance industry. There is a federal pension law in place, the Employee Retirement Income Security Act (ERISA), that restricts a state’s authority to regulate health plans (Kaiser Family Foundation, The Federal Courts' Role In Implementing the Affordable Care Act, 2014). Before the ACA was passed, states argued that this law should be repealed and that they should have more autonomy over health insurance regulation. States are responsible for overseeing medical education, medical licensing, the quality of care in healthcare delivery systems, administering workers compensation, and consumer-protection efforts, which include malpractice suits (Sommers & Epstein, 2011). Dating back to the 1920s, states were also in charge of setting capitalization requirements, regulating marketing and enrollment activities, and in some states even setting the rates paid by insurers to providers in hospitals (Kaiser Family Foundation, The Federal Courts' Role In Implementing the Affordable Care Act, 2014). Despite these rules set forth, the relationship among providers, insurers, and regulators was one where everyone benefitted. Providers would charge insurers high rates that would be paid without question, while regulators did little to make sure that insurance companies were capitalizing their profits (Kovner & Knickman (Eds.), 2011, p. 38). Patients were not being treated fairly and many services were not covered. It took two decades for more regulations to be enacted. In 1974, ERISA was passed with the intention of preventing unfair denial of pensions to employees (Kovner & Knickman (Eds.), 2011, p. 38). As part of the law, states could no longer regulate employee benefit programs. This provision was thus used as a loophole for companies that were self-insured. Under this provision, self-insured companies would be exempt from state capitalization, state taxes imposed on insurers, and all other state regulations (Kovner & Knickman (Eds.), 2011, p. 38). Self-insured companies therefore did not have to comply with state regulations that promoted patient protection and are only required to adhere to federal regulatory requirements (Longest, 2010, p. 236). Because the federal government prior to 2010 generally did not impose any requirements, most of the self-insured companies remained unregulated (Department of Health and Human Services, 2012). As more private firms learned about this loophole, more became self-insured rather than opting to get coverage through private plans. The American public pressured Congress to act against the managed care industry, however, it was not until 2010 with the enactment of the ACA that comprehensive federal oversight was finally imposed over the private health insurance industry. As part of the implementation of the ACA in states, Medicaid was supposed to be expanded allowing for hundreds of thousands of new enrollees, healthy and sick, to get the care they needed and to finally close the coverage gap. However, Pennsylvania chose to go a different route.

### Healthy Pennsylvania – The Original Plan

In 2010, shortly after the ACA was signed into law, Governor Corbett, who was the state attorney general at the time for Pennsylvania, filed a complaint with twenty-one other plaintiffs challenging the constitutionality of the ACA. They claimed that states having the responsibility to maintain and qualify healthcare coverage, or else be forced to pay a penalty was, “an unprecedented encroachment on the sovereignty of the Plaintiff States and on the rights of their citizens” (Florida, N. D. O., Bruning, J., General, A., Abbott, G., Shurtleff, M. L., King, T., & Suthers, J. W. Case 3, November 23, 2010). The unconstitutionality was primarily in regards to the, “unlawful capitation or direct tax” forced upon the states if they were non-compliant during the implementation phase of the ACA. The contention surrounding the ACA made it clear that the state of Pennsylvania would not support Medicaid Expansion once state attorney general Thomas Corbett became governor-elect. The complaint also revealed that these plaintiffs were not in agreement with Congress and that they believed Congress lacked the constitutional authority to, “impose a mandate that all citizens buy something…or pay a penalty” (Florida, N. D. O., Bruning, J., General, A., Abbott, G., Shurtleff, M. L., King, T., & Suthers, J. W. Case 3, November 23, 2010). The states associated with the plaintiffs also did not want to relinquish their control over current standardized practices of the Medicaid program. This furthered their decisions to opt out of the Expansion Program and to instead file waivers for alternative insurance plans.

In the state of Pennsylvania, the house and senate majority are Republicans, and the state’s governor, Thomas Corbett, is also a Republican. Governor Corbett wanted Pennsylvania’s commonwealth to have access to quality affordable care. He believed that the best solutions in terms of health reform are developed at the state and local level. Instead of expanding the state’s Medicaid program, he decided to propose an alternative: *Healthy Pennsylvania*. *Healthy Pennsylvania* had three main priorities: improving access, quality, and affordability (The Department of Public Welfare, 2013). While still keeping the market private, Governor Corbett wanted to encourage better coordination among patients, providers and insurers. This program was meant to protect the taxpayers and to reduce government bureaucracy in order to provide care to the most vulnerable of Pennsylvania’s populations.

Reforming Medicaid is the first of the three core objectives detailed in the operation portion of *Healthy Pennsylvania* (The Department of Public Welfare, 2013). This included simplifying the benefit designs, improving personal accountability with the application of work search requirements and job training opportunities, providing a safety net for vulnerable populations and emphasizing waste-reduction, fraud, and abuse in service delivery (The Department of Public Welfare, 2013). Simplifying the benefit package included breaking down the current packages into two commercial-like alternatives that would be similar to what is provided in commercial markets for employees covered through employer-sponsored insurance. This system would be designed to work in conjunction with private insurance markets.

To increase personal responsibility, recipients would be actively engaged in their healthcare delivery systems and have a primary role in their own health outcomes. The plan encouraged individuals to forgo using emergency room services inappropriately and to instead seek out a primary care physician through the elimination of co-payments (The Department of Public Welfare, 2013). However, a ten-dollar penalty co-payment would be imposed on audited individuals if they used the emergency room inappropriately (The Department of Public Welfare, 2013). Monthly premiums based on incomes would be enacted at the individual as well as the household level. These sliding scale premiums would begin above 50% of the federal poverty level (FPL) and would continue up to 133% of the FPL at no more than twenty-five dollars, but had the potential to increase in the future (The Department of Public Welfare, 2013). Premiums would be reduced if healthy behaviors were practiced and individuals were actively engaging in work search requirements with limited exceptions. Pennsylvania’s waiver proposal required that able-bodied adults between the ages of 21 and 64 be registered for work with the state Department of Labor and Industry and be actively engaged in work search or job training activities as a condition of eligibility (The Department of Public Welfare, 2013). Failure to comply would result in ineligibility for up to nine months. This provision required that the Department of Welfare and the Department of Labor and Industry would collaborate to provide linkages to job opportunities for the unemployed and to help implement the work search stipulation. This would be done using a free system for employers and employees, JobGatewaySM enabling non-working Medicaid recipients the ability and opportunity to become more self-sufficient (The Department of Public Welfare, 2013). According to the *Healthy Pennsylvania* proposal, it is a known fact that working individuals are healthier. Thus, requiring employment would create a pool of individuals who would be deemed “low-risk” (The Department of Public Welfare, 2013). Job training activities would be an opportunity that Medicaid recipients could utilize either online or in person and would offer the best practices for employment gain.

To increase accessibility, Pennsylvania would utilize market competition to provide more options for provider choice to individuals not currently eligible for Medicaid. These individuals would have incomes between 0-133% of the FPL (The Department of Public Welfare, 2013). These individuals would be provided with federal funds (subsidies), set aside and would not be required to participate in the state federal exchange (The Department of Public Welfare, 2013). Individuals deemed “medically frail,” including individuals who are mentally and/or physically impaired, would also have the option of continuing to be covered under the traditional Medicaid program (The Department of Public Welfare, 2013). Monthly premiums would be set forth based on income but again, would be reduced if healthy behaviors were practiced.

The final core objective is to stabilize financing. Pennsylvania had the intent of managing high-cost expenditures and producing measurable outcomes. Medicaid itself is considered to be a growing program with high costs that make it difficult to meet the needs of other program areas, such as education (The Department of Public Welfare, 2013). Pennsylvania would employ the skills of consumers, health care professionals, business leaders, and insurers to design a new innovative payment and delivery model that would maximize quality of care.

Pennsylvania’s waiver submission was similar to the waivers developed and submitted by Arkansas and Iowa (both of which were approved), however, it contained some key differences. All three states wanted to implement Medicaid Expansion by using the Medicaid funds as premium assistance to purchase coverage for some or all newly eligible Medicaid beneficiaries in Marketplace Qualified Health Plans (The Department of Public Welfare, 2013). Pennsylvania, like Iowa, proposed waiving its obligation to provide wrap-around benefits and to impose premiums not otherwise allowable by federal law (The Department of Public Welfare, 2013). Pennsylvania’s *Healthy Pennsylvania* waiver proposal also included provisions that would affect populations that are currently eligible for Medicaid coverage. Compared to Iowa and Arkansas, Pennsylvania wanted to exclude the age groups of 19-20 years old as well as limit parents who qualified to only being eligible if they were between 33% and 138% of the federal poverty level. Those in the 19-20 year old age group would be covered under Medicaid managed care. In Iowa, premiums can be waived if healthy behavior is practiced, however, in Pennsylvania, these premiums are solely *reduced* if there is active participation in healthy activities AND participation in work search requirements. *Healthy* Pennsylvania gained enough support, however, to be approved by the CMS in August of 2014. Whether it was to gain support for the ACA or for *Healthy Pennsylvania,* there were key players that played a crucial role in aiding the implementation and public perceptions of both programs.

### Key Players

Lobbyists have a vested interest in many laws in the United States, and have continued to make their preferences known before laws are implemented. The Patient Protection and Affordable Care Act (ACA) was a primary example of interest groups making sure their demands were met, which in the end had little to do with reducing the number of uninsured Americans in the United States. The cooperation of insurance agencies was a huge component in the success of the ACA. However their cooperation came with a caveat: an individual mandate that would bring more youth into the system to cover the costs of older individuals (Quadagno, 2011). With the individual mandate in place, private insurance companies were willing to accept stricter regulations, however, they were unwilling to accept any alternatives to private insurance. This was out of the fear that a public insurance option would outcompete private insurance coverage options specifically in terms of price and quality (Quadagno, 2011). The response was a campaign to educate the public with advocacy hotlines and letters sent to industry employees. Attacks were made at the local level, where many individuals and organizations attacked Congressional members in town hall meetings knowing their message would spread rapidly through a host of radio talk shows (Hamburger and Geiger, 2009). When the final law passed, despite stricter regulations, there was no public option and the individual mandate was included (Kaiser Family Foundation, Medicaid moving forward, 2014). Government subsidies would be used to relieve the financial burden from individuals who were unable to afford coverage, and the insurance companies would provide benefits and administrative costs. Another important interest group were employers. With the ACA in place, employers would be responsible for providing some type of employer-sponsored insurance (The Department of Public Welfare, 2013). Unlike the insurance companies, they favored the public option, where healthcare coverage would be virtually universal. When the public option was deleted from the law, unions rallied in opposition against an excise tax that would be imposed on insurers of high-cost employer-based plans. Despite a slight delay, the tax was still implemented. Staunchly opposed religious groups also opposed the ACA because they did not believe the federal government should be giving funds to people who may use them to pay for abortions. They too lobbied heavily for abortion restrictions (Quadagno & Rohlinger, 2009). Their efforts succeeded when language in the law was changed and any health plan that received federal subsidies would be banned from covering abortions (Kaiser Family Foundation, Medicaid moving forward, 2014). Finally, physicians, who in the past had played a strong role in health reform through the American Medical Association (AMA), had differing opinions regarding their support of the ACA. These opinions were dependent upon their specialty and which groups they were aligned with. The Physicians for a National Health Program believed that private health insurance options should be eliminated altogether, while the AMA continued to favor tax advantages for health savings accounts (Quadagno, 2011). Overall the ACA has restructured the nation’s entire healthcare system, covered millions more, and has the potential to slow healthcare inflation. However, only time will tell if these changes will have the best interests of America’s public in mind.

### The Media’s Perspective

Partisan ideology will always be an issue when addressing contended political and federal legislation. The media can play a key role in the information they choose to relay to the public. The public may choose to read an entire article, but may be left with only a few words and phrases that resonate in their mind such as an “increase in premiums,” “re-insurance,” or “death panels.” For most Americans, the true concern comes down to dollars and cents – the cost. Given the complexity of the United States health care system as well as the laws that regulate this system, many Americans may interpret health care programs in place differently. When information is spewed out in articles, most of the general public is not interested in the source of this information, but the information itself. Depending on the source, bias can arise as a factor, which can potentially skew the information presented.

When dissecting the governor’s *Healthy Pennsylvania* proposal, the governor did not believe that the taxpayers should be “burdened” with rising costs and that, “Medicaid takes away from other program areas like education” (The Department of Public Welfare, 2013). Repeated words such as “safety-net,” “individual responsibility,” “government bureaucracy,” “easy to understand, seamless approach” made the plan seem individualistic and in the best interest of Pennsylvania’s most vulnerable populations (The Department of Public Welfare, 2013). It was claimed that the proposal would yield as many as 520,000 eligible low-income residents able to use Medicaid Expansion funds to purchase commercial insurance, which was stated to be an “anticipated” number of enrollees in this private option (The Department of Public Welfare, 2013).

Many opponents see the ACA as the “Un-Affordable Care Act” with the goal of adding millions of able-bodied adults to Medicaid and exacerbating the problem of access. They believe expansion greatly increases demand for services, but does nothing to increase the supply of health care providers accepting Medicaid patients. Compounding the problem is a perverse funding formula that prods states to attack the truly needy with cuts to essential services and simultaneously giving preferential treatment to adults without any disabilities or dependent children. According to these groups, it is important to remember that every additional dollar spent on Medicaid is one less dollar for education, roads, public safety, or tax relief. Instead of fulfilling the promises of lowering premiums in the state, Medicaid Expansion is likely to drive them up. Once enrollees make even one dollar over the eligibility threshold, they will be subjected to hundreds of dollars in health care costs on the ACA exchange. Overall, the federal law is projected to shrink the national economy by the equivalent of 2.5 million full-time (FTE) workers (Congressional Budget Office, 2014). Thus according to projections, the added cost of Medicaid expansion, along with the exchange subsidies, will shrink the state economy by an estimated 100,630 full-time workers in Pennsylvania, given the state’s population as a share of the nation (Congressional Budget Office, 2014).

### Tradeoffs

Some key tradeoffs include: potential unknown long-term adverse effects and some policy alternatives may cost taxpayers money to pay extra into a private insurance option. However, opting into this alternative will increase the amount of individuals currently uninsured to be eligible for coverage. Finally, it could further social disparities by increasing the number of fraud cases reported and ostracize certain vulnerable populations from obtaining coverage.

# alternative solutions

This section explores the alternative solutions made available by the Patient Protection and Affordable Care Act of 2010 (ACA). The analysis discusses and evaluates the best alternative options for the current U.S. healthcare delivery system. Finally, this section concludes with recommendations in an effort to insure more individuals and to create an overall efficient healthcare structure.

## Medicaid expansion + healthy Pennsylvania as aprroved by the centers for medicare and medicaid

Under the ACA, Medicaid was expanded to include all non-elderly individuals with income levels at or below 138% of the FPL. Under the law, 100% funds would be provided by the government to the states until 2016, where thereafter it would decline to 90% in 2020 and the future (Kaiser Family Foundation, Medicaid moving forward, 2014). The Supreme Court ruled this provision optional and therefore state participation in Medicaid Expansion is not forced. As of June 2014, 27 states, including DC, have expanded Medicaid. States can decide to implement Medicaid expansion at any time, meaning this is still an option for Pennsylvania. Regardless of Expansion, all states are required to establish streamlined, coordinated, and automated Medicaid eligibility and enrollment systems to encourage enrollment in Medicaid and further the continuity of coverage (Kaiser Family Foundation, Medicaid moving forward, 2014). Alternative solutions have been suggested by various states, where generally federal funds are to be utilized for consumers to purchase private plans.

On August 28, 2014, Pennsylvania’s *Healthy Pennsylvania* Proposal was approved by the CMS. However, not everything that was proposed was granted. The $25 premiums that were to be imposed apply only to individuals between the income levels above 100% of the FPL, and were reduced to 2% of the individual’s income (Kaiser Family Foundation, Medicaid moving forward, 2014). Premiums can be reduced if healthy behaviors are exhibited. Copayments will not be utilized unless emergency rooms are used inappropriately and therefore an $8 copay can be charged (Kaiser Family Foundation, Medicaid moving forward, 2014). Taxpayers will absorb those copayments and pay these costs. In Arkansas, this has led to over-utilization without financial penalty or consequences and further reduces patient-engagement (Kaiser Family Foundation, Medicaid moving forward, 2014). Care will be provided once contracts with managed care organizations have been established. The CMS detailed that, “Medicaid managed rules continue to apply under the demonstration, although as stipulated in the demonstration, the commonwealth may rely on state or federal commercial standards when those standards are at least, “as robust as Medicaid standards” (Kaiser Family Foundation, Medicaid moving forward, 2014). Finally work search requirements were removed from the proposal, however, the state will engage in employment encouragement through the provision of career coaches. Those who choose to participate in the Encouraging Employment Program will be eligible for premium reductions.

The new *Healthy Pennsylvania* plan takes a black and white approach, separating the population into low-risk and high-risk plans (Kaiser Family Foundation, Medicaid moving forward, 2014). Because the plan is also partially funded by senior-citizen Medicare Advantage Plans, almost 600,000 Pennsylvanian seniors can lose their plans as well as the benefits that come with enrollment on a Medicare Advantage plan (Kaiser Family Foundation, Medicaid moving forward, 2014).

### Evaluation of solutions

These solutions are both fairly new and have little evidence in regards to evaluation. It will be interesting to see how each solution will fare and which states will make the right choice, either offering private plans or moving forward with the federal Medicaid Expansion. Economically, state variations will reveal the benefits and faults of different plans. Lastly, how individuals cope to changes in health reform will be a strong determinant of future change.

There are six problems that could potentially arise with the new plan in place.

1. **Access**. If the new plans reimburses at a higher rate than traditional Medicaid, health care providers will give precedence to the able-bodied adults that comprise the expansion population, while the needy traditional Medicaid patients will be considered last. This issue of access could be exacerbated in Pennsylvania since 59 of the 67 counties are classified as primary care shortage areas by the Federal Health Resource and Services Administration (Archembault, 2014).
2. **Costs**. Without expansion, the program is estimated to cost $40.9 billion per year by 2022 driving costs up $24 billion from what they are today (Holahan, Buettgens, Carroll, Dorn, 2012). It was also decided that individuals enrolled in the Medical Assistance for Workers with Disabilities (MAWD) program, would be maintained in their current plan instead of being enrolled into the new expansion program. This will result in higher costs for commonwealth taxpayers. It will also eliminate the portion of the promised “savings” under the original *Healthy Pennsylvania* plan (Archembault, 2014). The final expansion agreement was hasty and included limited information in regards to the budget neutrality of the deal. If a budget neutrality provision is not clearly defined, billions of dollars more may be spent on the Medicaid program than originally projected (Archembault, 2014).
3. **Costs can shift onto private insurers**. As more enrollees are added to a program, not enough care may be reimbursed and physicians and hospitals will shift the additional loss onto private coverage in each state (Archembault, 2014)
4. **Large out-of-pocket tax cliffs may be created**. Governor Corbett’s *Healthy Pennsylvania* creates tax cliffs that have the potential to trap new expansion enrollees in government dependence (Archembault, 2014).
5. **Work disincentive may occur**. The new plan encourages enrollees to remain under the 138% FPL cutoff because these will be the individuals who are not forced to pay premiums (Archembault, 2014). These individuals will thus be less inclined to work longer hours, will hide any additional income received, and will avoid seeking higher-paying jobs in order to maintain their health insurance coverage.
6. **Seniors may lose Medicare Advantage**. Medicaid expansion under the ACA is partially funded by reductions in payments to seniors’ Medicare Advantage plans. This will be especially harmful for low-income seniors that cannot afford supplemental coverage to cover increasing out-of-pocket costs (Archembault, 2014).

### Recommendations

1. **To get as many states as possible to choose Medicaid Expansion**

*Healthy Pennsylvania* is considered a “five–year demonstration project” where the state has the ability to terminate it as long as it develops a phase-out plan and notifies the CMS. Therefore because Tom Wolf is now the governor-elect, it is likely that Medicaid Expansion will be implemented and can cover more individuals.

1. **Define terms**

If the laws and regulations themselves are poorly defined and incomprehensive, it only produces a more confused public. The system is convoluted and full of ambiguity when it comes to the language used in laws regarding health care. Laws are left open to change, however laws pertaining to the health insurance market should be created with less ambiguity so there is less room for high cost and more room for coverage opportunities.

1. **Regulating insurance companies**

Insurance companies need to be regulated by the federal government so that price and quality can be truly measured. As long as the states are in charge of regulation, the insurance companies and their interest groups will continue to thrive.

1. **Lobby Congress for a Public Option**

Advocates and interest groups can collaborate in their efforts for change. A public option would take out much of the confusion and would help reduce medical expenditures. The federal government can also act directly as an overseer. If public insurance is no longer viewed as “socialistic,” maybe more appropriate use of our healthcare system will be utilized.

1. **Increase Reimbursement Rates**

If reimbursement rates were increased, or physicians received more incentives, physicians would be more likely to accept Medicaid beneficiaries. Currently, the number of physicians accepting Medicaid beneficiaries is low adding to problems with access to care and delaying care. A study done by Sandra Decker, an economist with the National Center for Health Statistics, revealed that on average only “64.7% of primary care physicians accepted Medicaid patients in 2011 and 71.7% of physicians in specialties accepted Medicaid beneficiaries” (Decker, S. In 2011 nearly one-third of physicians said they would not accept new Medicaid patients, but rising fees may help, 2012). With incentives and higher reimbursement rates these problems could be addressed and better health outcomes should result. Under the ACA, these rates are supposed to increase to 100% for the years 2013 and 2014. It is hoped that this will consequently result in physician acceptance of new Medicaid patients. Nonetheless, policy changes should be made in order to keep these reimbursement rates high.

# Conclusion

More needs to be done in order for the nation’s health needs to truly be addressed. Medicaid has been proven to increase patient access to prescription drugs, preventative care, outpatient and hospital care, and to improve financial security (Kaiser Family Foundation, Medicaid moving forward, 2014). It is linked with reduced mortality, increased access to care, and increased self-reported health status (Kaiser Family Foundation, Medicaid moving forward, 2014). It effectively meets critically important needs and its cost growth of 6.1% is lower than any other coverage option (Greenhalgh, 2013). Medicaid expansion would open the door for tens of thousands of job opportunities and would create $5.1 billion in economic activity across the state in the first two years by boosting employee income, driving consumer spending, and generating tax revenue (Kaiser Family Foundation, Medicaid moving forward, 2014). The expansion would also be a cost-saving investment for Pennsylvania taxpayers potentially saving up to $1.6 billion from reductions in “uncompensated” care costs and another $1 billion by allowing people currently covered through limited benefits packages to full coverage under expansion (Greenhalgh, 2013). Finally, an additional $50-80 million can be saved in new state revenue from the 5.9% gross receipts tax on Medicaid managed care plans between 2014 and 2016. Solutions need to be re-evaluated so that the health of Pennsylvania’s population is put first.

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