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The Expansion of the Affordable Care Act and its Effect on Stakeholders

Medicaid sustainability comprises factors such as legislation, public opinion, and health care providers intervention. For the policy analyst, there is a need to understand and bring these elements together in order to meet the needs of the stakeholders involved. There is Medicaid before and after the Affordable Care Act (ACA). Before the Affordable Care Act, Medicaid was not readily available for low-income individuals. The Kaiser Family Foundation reported that in 2013 a family of four had to amount to $ 15, 000 per year to qualify for Medicaid (“ USCF/UC Hastings Consortium,” n. d.). Due to the low limits on income, many Americans remained without health insurance. About 47 million Americans were not able to afford private health insurance or be eligible to apply for Medicaid (“ USCF/UC Hastings Consortium,” n. d.). In 2010, when the Affordable Care Act was enacted, it required all individuals to have health insurance. ACA qualifications to apply for Medicaid are income-inclusive only, compared to prior requirements of income, family status, and level of disability before ACA (“ USCF/UC Hastings Consortium,” n. d.).

In 2015 Medicaid annual enrollment in the State of Pennsylvania increased due not only to Medicaid expansion but also because of the individual mandate that required all individuals to acquire health insurance. In 2013, there was a decrease of 2. 6 percent of Medicaid annual enrollment, by 2014, it went up to 1. 6 percent and by 2015 enrollment increased to 9. 1 percent (“ Ballotpedia,” n. d.). In 2012 the U. S. Supreme Court decision in *National Federation of Independent Business v. Sebelius* ruled that Medicaid expansion was no longer required and allowed each state to expand voluntarily (Urban Institute, 2013). Medicaid is managed by the Centers for

Medicare and Medicaid Services (CMS). And as of 2017, 31 states had expanded Medicare (Norris, 2018). In 2015, The State of Pennsylvania was one of the 31 states that enacted Medicaid expansion with a requirement for participants to earned less than 138 percent below the federal poverty level, which by 2017, amounted to $ 16, 643 for an individual and $ 33, 948 for a family of four (“ Ballotpedia,” n. d.).

The history of Medicaid expansion in Pennsylvania started when former Republican governor Corbett communicated with the federal government to promote, Healthy Pennsylvania, a version of Medicaid expansion designed by his office, approved in 2014 (Norris, 2018). Corbett’s plan included work requirements, which was acquiring traction due to the “ Trump Administration’s approval of five state’s work requirements” (Norris, 2018). Including work requirements as part of Medicaid expansion stems from the state enacting legislation and then asking for federal approval by the Center for Medicaid and Medicare Services (Norris, 2018).

In 2018, PA lawmakers passed bill HB2138 which required Medicaid participants to work at least 20 hours per week (Norris, 2018). Also, Corbett ‘ s Healthy Pennsylvania included three different health plans depending on health status and eligibility compared to a single Medicaid system under ACA (Norris, 2018). Although Corbett’s plan had support from certain insurance carriers; they ended up having difficulty getting enough providers to participate due to commercial plans having higher reimbursement rates than them (Norris, 2018). In 2015, when Democrat Governor Wolf took office, he vetoed work requirements and promoted Medicaid expansion based on the Affordable Care Act (“ Healthinsurance. org,” n. d.). As of August 2018, the

state of PA has a Medicaid enrollment of 2, 888, 743. And, 700, 000 participants have enrolled due to the expansion (Norris, 2018)

Tradeoffs are present in ACA's expansion of Medicaid that affects states and policymakers. According to the website HealthInsurance. org (n. d.), if the state of Pennsylvania did not expand Medicaid, federal funding of $ 37. 8 billion would have been missed over the next ten years. Between 2014 and 2016, if a state incurred in Medicaid expansion, the federal government covered 100 percent of the cost for newly eligible participants (" Healthinsurance. org," n. d.).

Following those years, the Federal Medical Assistance Percentage (FMAP), which is the federal reimbursement for medical expenses, would decline to 90 percent (Badger, 2017). Before ACA, FMAP included a state's per capita income where a higher FMAP was shared with low capital income states. ACA changed federal reimbursement and priority was given to the states that had Medicaid expansion programs (Badger, 2017). Badger (2017) reported that states that opted for Medicaid expansion received federal payments at the expense of non-expansion states.

According to Sommers et al., (2017), insurance coverage through Medicaid expansion affected patients positively through increased health care utilization, disease treatment and outcomes, self-reported health, and mortality. Sommers et al., (2017), reported a link between having health insurance and financial security by the reduction of unpredictable medicals costs.

In their study, Sommers et al., (2017), reported positive outcomes for patients by “ increased outpatient utilization and having a primary care physician, increased preventive outcomes including cancer screening and labs, prescription drug utilization and adherence, increased rates of diagnosing chronic conditions, increased treatment for chronic illnesses, improved depression outcomes and self-reported health”.

In general, ACA increased the use of healthcare coverage across the nation and has positively affected the use of health care utilization, disease treatment, and self-reported health. However, the federal government counts on states opting for Medicaid expansion so that prices in the marketplace remain competitive. According to the Urban Institute (2013), the federal government paid 57 percent of health care costs to states without Medicaid expansion. Lack of Medicaid expansion affect eligibility for insurance subsidies and leaves a large gap for adult eligibility on those states. The Urban Institute (2013) reported that 11. 5 million uninsured adults with incomes below poverty would be ineligible for assistance despite been able to qualify for marketplace subsidies.

However, not everyone is pro-Medicaid expansion. Owcharenko (2013) states that Medicaid expansion will be detrimental for taxpayers and patients. The current Medicaid system is overburdened with providing care for pregnant women, the disabled, uninsured children, and senior citizens. As of 2013, Medicaid uses 23 percent of state budgets, if it continues to increase, budgets for “ education, emergency services, transportation, and criminal justice” will decrease (Owcharenko, 2013).

Public perception plays a significant role in policymaking. According to Jha (2014, October), health care debate in America does not propose a healthy discussion of trade-offs. The continued rise of healthcare costs and the deficits running over $1 trillion a year can lead to unstainable health care spending. Opposing those facts, the US has a growing number of uninsured Americans and legal immigrants. The American public takes only one side on issues that affect them directly without looking at trade-offs when choosing sides.

Jha (2014) suggests looking at tradeoffs from different angles to determine which side its best for one’s agenda or the whole population at large. Jha (2014) gives examples of how some stakeholders hold biases toward making choices such as wanting insurers to bargain with health care providers to lower costs but wanting to have more options. And how taxes will offset subsidies but will downplay for small businesses to flourish (Jha, 2014). Without an honest look at tradeoffs, the public can develop a misconception of disinterestedness where there might be a belief that there is no solution to the problem or that healthcare providers are in it for the money (McLaughlin & McLaughlin, 2014).

In addition to offsetting negative public perception and disinterestedness through looking at both sides of the tradeoffs, providing balance for stakeholders through process innovation, risk-taking, health policy analysis, and governance “ sense-making” are necessary. Leadership that is dynamic, inclusive and “ networked” aids in the process of innovation (McLaughlin & McLaughlin, 2014). Also, healthcare leaders need to view failure as part of the process of succeeding to improve outcomes and innovation.

McLaughlin & McLaughlin (2014) suggest for policy analysists to engage in self-evaluation and understand which risks are the professional able or willing to handle. Overall, healthcare leaders who have a stronghold in understanding governance will be able to upgrade and guide an organization through needed changes for sustainability.

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