JOURNAL OF HEALTH CARE FINANCE

Summer 2021

Medicaid Expansion Under the Affordable Care Act is the Best Long-term Choice for All States

Shannon Garrison, MBA, MJ

I. Introduction

A study run by the Center on Budget and Policy Priorities found that 19,200 lives were saved by Medicaid expansion under the Affordable Care Act.[1] The same study estimates 15,600 lives were needlessly lost in states that did not expand.[2] Healthcare for uninsured individuals can be cost-prohibitive. This is especially true with preventative care. Chronic illnesses are more easily treated if caught early.[3] In fact, some illnesses, like some types of diabetes, can be prevented with proper early interventions. Other chronic illnesses, like asthma, can end in acute complications if not properly monitored. Access to healthcare for early detection, intervention, and monitoring saves lives. Kenneth King of Birmingham, Alabama is a great example of those losing out because he lives in a state that has not passed a Medicaid expansion bill.[4] At 57 years old, he makes enough money to get by and rent an apartment but not enough for insurance premium expenses.[5] After having emergency heart surgery, he found himself buried in bills he could not pay.[6] He also must decide which of his two prescriptions to take because he cannot afford both that his doctor prescribed him.[7] King makes too much money for traditional Medicaid but lives in a state unlikely to expand, so he is unsure when or if he will get coverage.[8] Not taking his heart medicine can lead to any number of problems for him down the line.

Following doctor's orders and protecting one's life should not be a financial decision. All states should expand Medicaid under the Affordable Care Act because they can take advantage of higher matching funds from the federal government. This expansion population will obtain better access to preventative care, allowing for lower costs and higher quality of care to those state residents in the long term.

This paper will discuss the background of the ACA. The legislation was difficult to pass in any form but by focusing on access to healthcare over cost, an agreement was struck. There are several provisions driving toward greater access, but the Medicaid expansion is a very important part of the goal.[9] To make sure the expansion works, Congress offered a great deal of financial incentives to states willing to expand Medicaid.[10] As this paper will discuss, research shows that state decisions regarding Medicaid expansion (positive and negative) tracks along political party lines.[11] Those states that have expanded, despite politics, have not spent extra money in their

[1] https://www.cbpp.org/research/health/chart-book-the-far-reaching-benefits-of-the-affordable-care-acts-medicaid-expansion
[2] Id.
[3] https://www.cdc.gov/pcd/issues/2019/18_0625.htm
[4] https://wbhm.org/feature/2021/will-alabama-and-mississippi-expand-medicaid-to-low-income-adults-this-time-around
[5] Id.
[6] Id.
[7] Id.
[8] https://wbhm.org/feature/2021/will-alabama-and-mississippi-expand-medicaid-to-low-income-adults-this-time-around/
[9] PATIENT PROTECTION AND AFFORDABLE CARE ACT; ELDER JUSTICE ACT, 111 P.L. 148, Part 1 of 3, 124 Stat. 119, 121, 111 P.L. 148, 2010 Enacted H.R. 3590, 111 Enacted H.R. 3590
[10] Medicaid Expansion Act, 2019 Bill Text SC H.B. 5476
[11] ARTICLE: The Strange Politics of Medicaid Expansion, 47 J. Marshall L. Rev. 947

budgets.[12] The paper will then discuss the need for preventative care and the lack of overall healthcare coverage on future illness burden.[13] It will also acknowledge the counterpoints to expansion. Among the most cited counterpoint, that state healthcare budgets will soar when the federal matching funds revert to current Medicaid matching levels.[14] While this is a valid concern, the risks can be mitigated. The paper will show that state residents will be better off if Medicaid expansion becomes universal.

II. Affordable Care Act and the Medicaid Expansion Purpose

The Affordable Care Act (ACA) is one of the most challenged statutes in recent history.[15] It has been questioned as going too far by some but not going far enough by others.[16] Those that think it did not go far enough were looking for more universal coverage.[17] The purpose of the ACA and many of its provisions is to expand coverage to as much of the U.S. population as possible.[18] When the ACA was enacted, estimates of uninsured U.S. citizens were as high as 50 million people.[19] Recent studies estimate the uninsured rate, even 11 years into the ACA, at close to 30 million U.S. citizens despite all of the provisions the ACA tried to put in place.[20] It includes measures to cover those with pre-existing conditions and minimum coverage for employer benefits.[21] The ACA also allows individuals to purchase insurance on exchanges where they can get grants to offset costs.[22] Another path toward coverage for all is a clause to cover children up to age 26 under their parent's insurance.[23] Even with all these paths to coverage, the ACA takes on one more segment of individuals to get closer to covering everyone in the U.S. There are individuals that have an income too high to qualify for Medicaid, but they would still be unable to purchase coverage on an exchange or contribute any significant portion of their income to insurance premiums.[24] This group represented about 20 percent of Medicaid enrollment leading up to the COVID-19 epidemic.[25] The number of individuals that qualify for expansion has increased significantly with the COVID-19 epidemic, making this provision even more

[12] Federal Funding Insulated State Budgets From Increased Spending Related to Medicaid Expansion | Health Affairs
[13] Health-Related Outcomes Among the Poor: Medicaid Expansion vs. Non-Expansion States (plos.org)
[14] FMAP matching: https://fas.org/sgp/crs/misc/R43847.pdf
[15] ARTICLE: Affordable Care Act Entrenchment, 108 Geo. L.J. 495 (lexis.com)
[16] Id.
[17] Id.
[18] PATIENT PROTECTION AND AFFORDABLE CARE ACT; ELDER JUSTICE ACT, 111 P.L. 148, Part 1 of 3, 124 Stat. 119, 121, 111 P.L. 148, 2010 Enacted H.R. 3590, 111 Enacted H.R. 3590
[19] ARTICLE: The National Residency Exchange: A Proposal to Restore Primary Care in an Age of Microspecialization, 38 Am. J. L. and Med. 158
[20] J Law Biosci (June 2020) 7 (1): 1-12
[21] PATIENT PROTECTION AND AFFORDABLE CARE ACT; ELDER JUSTICE ACT, 111 P.L. 148, Part 1 of 3, 124 Stat. 119, 121, 111 P.L. 148, 2010 Enacted H.R. 3590, 111 Enacted H.R. 3590
[22] PATIENT PROTECTION AND AFFORDABLE CARE ACT; ELDER JUSTICE ACT, 111 P.L. 148, Part 1 of 3, 124 Stat. 119, 121, 111 P.L. 148, 2010 Enacted H.R. 3590, 111 Enacted H.R. 3590
[23] Id.
[24] https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/healthcare-in-us-aca/
[25] https://www.kff.org/medicaid/issue-brief/medicaid-expansion-enrollment-and-spending-leading-up-to-the-covid-19-pandemic/

important.[26] The ACA, therefore, added a section for expanding Medicaid.[27] This is for individuals whose income is below 138 percent of the poverty line and do not have an employer-based option.[28] With the larger group of citizens landing in this population since COVID-19 and the economic downturn caused by the epidemic, the matching medical cost percentages from the federal government were increased again for states willing to expand, under the American Rescue Plan Act of 2021.[29] This further shows the intent of the ACA and the U.S. legislature to cover this group of people. The extra 5 percent matching incentive provided by the American Rescue Plan Act of 2021 has shown this intent and reignited the debate on expansion for some states that have still been reluctant.[30] Originally, the ACA was written in a way that would require states to cover an expanded population. Congress attempted to withdraw federal funding of existing Medicaid programs for states that did not expand.[31] This penalty structure was struck down by the U.S. Supreme Court as unconstitutional in *National Federation of Independent Business v. Sebelius*.[32] The Court did not strike down other portions of the ACA, nor the entirety of the ACA as 26 states had asserted should happen.[33] The *National Federation of Independent Business* decision held that it was beyond Congress' power to penalize states in such a way.[34] Although the Supreme Court removed the penalizing portion of the provision, the incentive portion was upheld.[35] Further, despite the ruling, more than half of states expanded right away, and 4 more expanded in 2018.[36]

---

[26] https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/

[27] PATIENT PROTECTION AND AFFORDABLE CARE ACT; ELDER JUSTICE ACT, 111 P.L. 148, Part 1 of 3, 124 Stat. 119, 121, 111 P.L. 148, 2010 Enacted H.R. 3590, 111 Enacted H.R. 3590

[28] Id.

[29] 117 P.L. 2, 135 Stat. 4, 117 P.L. 2, 135 Stat. 4

[30] https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/

[31] Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 132 S. Ct. 2566, 183 L. Ed. 2d 450, 2012 U.S. LEXIS 4876, 80 U.S.L.W. 4579, 2012-2 U.S. Tax Cas. (CCH) P50,423, 109 A.F.T.R.2d (RIA) 2012-2563, 80 A.L.R. Fed. 2d 501, 53 Employee Benefits Cas. (BNA) 1513, 23 Fla. L. Weekly Fed. S 480, 2012 WL 2427810

[32] Id.

[33] Id.

[34] Id.

[35] Id.

[36] ARTICLE: The Inexorable Expansion of Medicaid Expansion, 39 N. Ill. U. L. Rev. 240

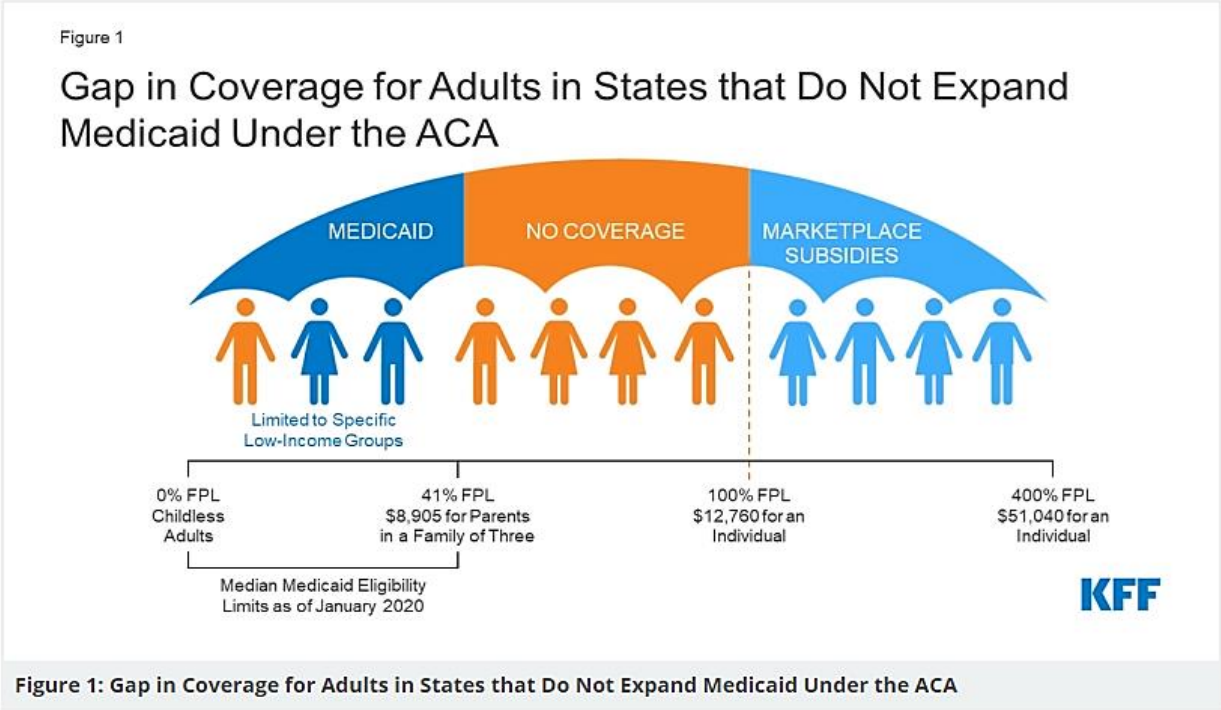


Figure 1: Gap in Coverage for Adults in States that Do Not Expand Medicaid Under the ACA

https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/

To incentivize expansion, the ACA allowed for a reimbursement rate of 100 percent of costs for the expansion population through 2016.[37] From there, rates were set to decline year-over-year until stopping at 90 percent of costs by 2020.[38] Even at 90 percent, this is much higher than the existing matching of funds that occurs for most states.[39] Since the passage of the ACA and the National Federation decision, Congress has tried to replace the penalties with a different twist. In the Medicaid Expansion Incentive Act of 2017, the proposal was to give a bonus to states that decided to expand, but the money would come from those states that did not expand Medicaid.[40] The statute failed to pass.[41]

The ACA has been through several challenges in court. One of the objections that were potentially irreconcilable had to do with the individual insurance mandate established by the ACA.[42] The individual mandate has been challenged several times, but when congress revoked the tax penalty for non-compliance, the individual mandate was deemed unconstitutional in December of 2019.[43] Because there is no longer a penalty for lacking coverage, the standing provisions that expand coverage are more important. Acknowledging the continued importance of Medicaid expansion, the legislature introduced the "States Achieve Medicaid Expansion Act of

[37] PATIENT PROTECTION AND AFFORDABLE CARE ACT; ELDER JUSTICE ACT, 111 P.L. 148, Part 1 of 3, 124 Stat. 119, 121, 111 P.L. 148, 2010 Enacted H.R. 3590, 111 Enacted H.R. 3590
[38] Id.
[39] FMAP matching: https://fas.org/sgp/crs/misc/R43847.pdf
[40] Medicaid Expansion Incentive Act of 2017115 H.R. 1826, 2017 H.R. 1826, 115 H.R. 1826
[41] Id.
[42] PATIENT PROTECTION AND AFFORDABLE CARE ACT; ELDER JUSTICE ACT, 111 P.L. 148, Part 1 of 3, 124 Stat. 119, 121, 111 P.L. 148, 2010 Enacted H.R. 3590, 111 Enacted H.R. 3590
[43] *Texas v. United States*, 2019 U.S. App. LEXIS 39479

2021" in February 2021.[44] If the act passes, it will continue the higher matching funds for states that expand regardless of when they choose to expand.[45]

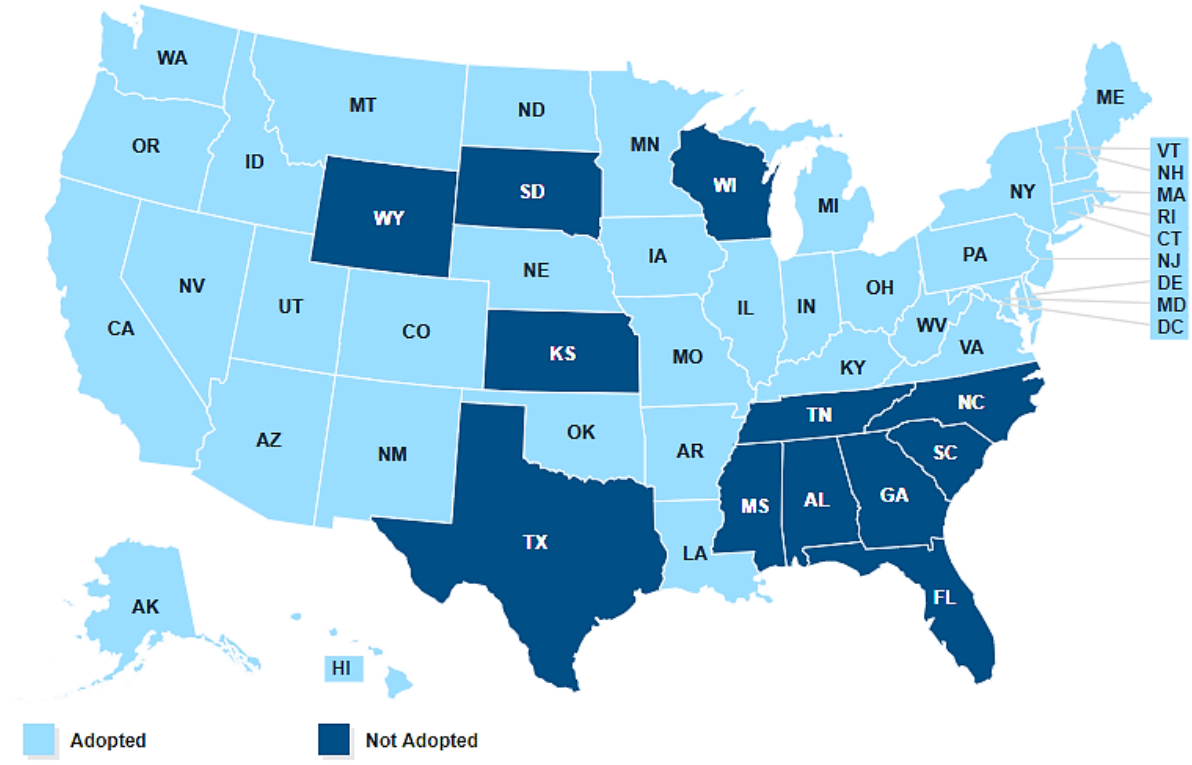
In July of 2021, three US Senators introduced a bill that would create an alternative to expansion.[46] Democrats Ralph Warnock and Jon Ossoff from Georgia and Democrat Tammy Baldwin from Wisconsin are leading the charge.[47] They would like to create a marketplace type plan, run by the federal marketplace, and make sure it has benefits that mirror those of expanded Medicaid plans.[48] It would serve the same population and hopefully close the coverage gap for their respective states.[49] They are trying to find a way around political blocks that they have in their respective states making it impossible, thus far, to secure true Medicaid expansion.[50]

III. State Expansion Efforts

As of March 2021, 39 states and Washington D.C. have enacted Medicaid expansion and 12 states have not.[51] Of those that have voted to expand, Missouri and Oklahoma have not yet put expansion in place.[52] Getting Medicaid expansion passed has been harder for states run by Republicans, either as a governor or a legislative majority.[53] Some Republican-led states moved right away, even when only a portion of their party agreed.[54] For example, John Kasich, the Republican governor of Ohio, pushed expansion through in October of 2013.[55] He did this despite the reservations of many members of his own party.[56] In Arizona, Republican Governor Jan Brewer threatened to veto any proposed bills until the legislature approved expansion.[57] Idaho's Republican governor, Butch Otter, did not move as quickly.[58] He waited until he was on his way out of office in 2018 and supported a ballot proposition that would expand Medicaid.[59] Governor Otter even participated in commercials, in which, he expressed that hard-working Idahoans deserved healthcare coverage.[60]

---

[44] States Achieve Medicaid Expansion Act of 2021, 117 S. 245, 2021 S. 245, 117 S. 245
[45] Id.
[46] Senators seek Medicaid-like plan to cover holdout states | The Seattle Times
[47] Id.
[48] [48] Senators seek Medicaid-like plan to cover holdout states | The Seattle Times
[49] Id.
[50] Id.
[51] https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map
[52] Id.
[53] ARTICLE: The Strange Politics of Medicaid Expansion, 47 J. Marshall L. Rev. 94
[54] ARTICLE: The Inexorable Expansion of Medicaid Expansion, 39 N. Ill. U. L. Rev. 240
[55] Id.
[56] Id.
[57] Id.
[58] Id.
[59] ARTICLE: The Inexorable Expansion of Medicaid Expansion, 39 N. Ill. U. L. Rev. 240
[60] Id.



https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?activeTab=map&currentTimeframe=0&selectedDistributions=status-of-medicaid-expansion-decision&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

In other states, there has been a recent push because of COVID-19 and the greater needs of state residents.[61] Studies have estimated a decline of 8.8 million people from employer coverage as a result of the COVID-19 pandemic and the economic fallout.[62] This trend will be worse in states that have not expanded since a lot of the individuals that are newly unemployed will not qualify for traditional Medicaid but will not have the means for commercial insurance without employer participation.[63] States like Florida have been adding Medicaid expansion to their ballot.[64] According to studies, they would lower the uninsured rate in the state by 852,000 residents if they expanded as of May 2021.[65] Other states have written expansion into their state constitutions to push resistant state leadership into action.[66] These new ballot measures show how voters are eager for their states to make sure they have coverage.[67] This is not surprising in the wake of the COVID-

[61] https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/
[62] J Law Biosci (June 2020) 7 (1): 1-12
[63] Id.
[64] https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/
[65] Expanding Medicaid would bring jobs, billions of dollars | Fort Myers Florida Weekly
[66] https://www.ama-assn.org/practice-management/medicare-medicaid/why-oklahoma-voters-put-medicaid-expansion-their-constitution
[67] Id.

19 epidemic. There are more people unemployed or underemployed, and perhaps that has put healthcare coverage is at the top of their minds. Oklahoma voters approved an amendment to their state constitution in 2020.[68] In July of 2021, this very Republican state has started services under the new expansion plan.[69] Before kicking off the program Oklahoma had approved more than 123,000 people for coverage.[70] The expectation is that more than 200,000 people will be covered under the expansion program since they are second to only Texas for having the highest rate of uninsured.[71]

Some states still resistant to expansion are looking for other ways to pay for care of the population that falls in the coverage gap. Each state can apply for a waiver for the funds to expand their Medicaid population.[72] The secretary of HHS has the option and obligation to make sure conditions are being met under the purpose of the ACA expansion clause before approving the waiver and therefore the increased FMAP matching.[73] In an effort to fund hospitals taking care of some of the previously and newly uninsured, Texas applied for a Medicaid waiver that would last the next ten years.[74] The Biden administration rescinded the waiver under a technicality that Texas had not allowed enough time for public comment.[75] This choice by the administration shows that it will be hard for the 12 remaining states to go around Medicaid expansion and still get federal funding for the uninsured population.[76]

After having trouble getting the state government to fully commit to implementation, Missouri added a state constitutional amendment.[77] The amendment to the Missouri Constitution states expansion members will be eligible July 1, 2021, and specifically states that Missouri officials will have proceeded with all necessary paperwork to the federal government by March 1, 2021.[78] Even with these provisions, the CMS request for expansion was withdrawn in May 2021 by the governor, Mike Parsons, because the state budget did not fund the expansion.[79] On July 1, 2021, protesters gathered in front of the Missouri governor's mansion to protest the lack of funding.[80] Over 270,000 Missouri citizens could get coverage if the governor follows the amendment.[81] Mississippi is another non-expansion state. It requires a supermajority in the legislature to recertify even basic Medicaid on a yearly basis.[82] When the ACA was passed, the Mississippi state legislature adjourned early with no Medicaid reauthorization and came back later to approve with no expansion.[83] This shows how far those in opposition were willing to go to avoid expansion in Mississippi. Maine became one of the first states to try and enact expansion

[68] Medicaid expansion takes effect in deep-red Oklahoma (apnews.com)
[69] Medicaid expansion takes effect in deep-red Oklahoma (apnews.com)
[70] Id.
[71] Id.
[72] Jrnl Legal Medicine, 40: 391-419
[73] Id.
[74] https://khn.org/morning-breakout/white-house-rescinds-medicaid-waiver-in-texas-over-flawed-approval- process/
[75] Id.
[76] Id.
[77] Mo. Const. Art. IV, § 36(c)
[78] Id.
[79] Missouri Governor Drops Voter-Approved Medicaid Expansion | joplinglobe.com
[80] Missourians Rally in Front of Governor's Mansion for Medicaid Expansion | State News | komu.com
[81] Id.
[82] ARTICLE: The Inexorable Expansion of Medicaid Expansion, 39 N. Ill. U. L. Rev. 240
[83] ARTICLE: The Inexorable Expansion of Medicaid Expansion, 39 N. Ill. U. L. Rev. 240

through a vote in November of 2017.[84] There, the Republican governor, Paul LePage was so opposed to expansion that he said publicly he would rather go to jail.[85] In 2018, Maine did file paperwork with CMS under the leadership of Governor LePage, but he asked the Trump administration to deny the request.[86]

To gain bipartisan support, some states have applied for Medicaid expansion waivers with a work requirement component. Arkansas was the first to obtain approval for a work requirement for their expansion population.[87] Michigan and New Hampshire are two of the states that followed their lead and asked for a work requirement.[88] Those requirements were generally approved under the Trump administration.[89] New Hampshire's work requirement was later declared unlawful by the US District Court of the District of Columbia, in *Philbrick v. Azar*.[90] The court's holding was based on a finding that Health and Human Services(HHS) did not adequately consider the loss of coverage that would occur under the approved New Hampshire waiver.[91] When Kentucky tried to go further than the other states to gain expansion acceptance by conservatives the waiver was denied by HHS.[92] Kentucky wanted to have work requirements and copayments for the expansion population.[93] This was seen as counter to the intent of Medicaid which is meant to help those who cannot afford health insurance or copayments.[94] Georgia applied for a waiver under what it calls "pathways to coverage."[95] It went further than work requirements by saying it would implement some of the private market methods; including premiums, copays, and no retroactive coverage.[96] Georgia also decided to forgo added FMAP percentages for their potential expansion population by applying only for expansion to those up to 100 percent of the poverty level instead of 138 percent.[97] This partial expansion population has received legacy FMAP percentages from HHS for other states, but Georgia has budgeted for that result.[98] Even if Georgia is willing to pay for the larger part of claims, the other portions of the proposed waiver would likely not stand up in court provided they get past the barrier, an approval from HHS.[99] Georgia has still not expanded Medicaid at this point.[100]

South Carolina is still fighting on both sides of the Medicaid expansion debate.[101] In July 2021, US House Majority Leader, Jim Clyburn spent time touring through South Carolina to garner support for Medicaid expansion in his home state.[102] At the same time, South Carolina Governor

---

[84] Id.
[85] ARTICLE: The Inexorable Expansion of Medicaid Expansion, 39 N. Ill. U. L. Rev. 240
[86] Id.
[87] Id.
[88] Id.
[89] Id.
[90] *Philbrick v. Azar*, 397 F. Supp. 3d 11, 2019 U.S. Dist. LEXIS 125675, 2019 WL 3414376
[91] Id.
[92] ARTICLE: The Inexorable Expansion of Medicaid Expansion, 39 N. Ill. U. L. Rev. 240
[93] *Commonwealth v. Regan*, 2019 Ky . App. Unpub. LEXIS 797, 2019 WL 5854032
[94] *Commonwealth v. Regan*, 2019 Ky . App. Unpub. LEXIS 797, 2019 WL 5854032
[95] Jrnl Legal Medicine, 40: 391-419
[96] Jrnl Legal Medicine, 40: 391-419
[97] Id.
[98] Id.
[99] Id.
[100] https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map
[101] Clyburn to push Medicaid expansion in series of town halls (apnews.com)
[102] Id.

McMaster is being outspoken in his opposition to any expansion of the program.[103] McMaster has told the press that accepting expansion under the higher federal reimbursement rates is selling out to Democrats and pushing problems down the road.[104] South Dakota has also not expanded, but major health care systems have banded together to try and gain enough signatures for a 2021 ballot measure.[105]

States who have not expanded are continuing to wrestle with the option. Since the ACA was just upheld by the Supreme Court for the third time in a decade, leaders can be fairly sure it is not going away.[106] As more information is available from those states that have expanded, they have more data to discuss. Also, a factor, as this paper discussed earlier, is the added financial incentives that have come from the American Rescue Plan Act of 2021.[107]

IV. Preventative Care is Beneficial and Allows for Future Cost Avoidance

When people are uninsured, they often postpone or skip preventative care. According to studies, uninsured adults receive preventative care at a rate much lower than recommended.[108] Recognizing the importance of preventative care, the ACA tried to increase access and use of preventative care in a couple of ways. First, the ACA stated that there were minimum requirements for preventative care for most insurance coverage through various services.[109] Second, coverage was expanded as this paper discussed earlier.[110] States that expanded Medicaid under the ACA showed a higher percentage of preventative care use among expansion members than the same cohort of people in states that decided not to expand.[111] This is despite the fact, some reports found those in the non-expansion states have an easier time getting a requested appointment than those in expansion states.[112] In other words, these patients could get an appointment but choose not to because of finances. There have been numerous efforts over recent years to increase primary care providers in underserved areas and increase preventative care opportunities, but those providers need to be accessed for impact.[113] The Increasing Primary Care Access Act of 2014 113 S. 1978 afforded several grant provisions for schooling just to get primary care providers to less affluent, underserved sections of the country.[114] However, primary care providers must be accessed by those residents to be helpful. The underserved areas addressed tend to be in an economic band also served by the Medicaid expansion section of the ACA.[115] Studies have shown that primary care participation lowers mortality rates.[116] Primary care providers are more likely to implement

[103] Id.
[104] Id.
[105] Medicaid expansion takes effect in deep-red Oklahoma (apnews.com)
[106] Medicaid expansion takes effect in deep-red Oklahoma (apnews.com)
[107] https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/
[108] https://www.ajpmonline.org/article/S0749-3797%2814%2900496-6/fulltext
[109] PATIENT PROTECTION AND AFFORDABLE CARE ACT; ELDER JUSTICE ACT, 111 P.L. 148, Part 1 of 3, 124 Stat. 119, 121, 111 P.L. 148, 2010 Enacted H.R. 3590, 111 Enacted H.R. 3590
[110] Id.
[111] Health-Related Outcomes among the Poor: Medicaid Expansion vs. Non-Expansion States (plos.org)
[112] Id.
[113] Increasing Primary Care Access Act of 2014, 113 S. 1978, 2014 S. 1978, 113 S. 1978
[114] Increasing Primary Care Access Act of 2014, 113 S. 1978, 2014 S. 1978, 113 S. 1978
[115] Id.
[116] ARTICLE: The National Residency Exchange: A Proposal to Restore Primary Care in an Age of Microspecialization, 38 Am. J. L. and Med. 158

coordination of care, counsel on safe health habits, and keep up with preventative care, such as screenings and immunizations.[117]

Perhaps one of the most important, practical impacts of lower preventative care participation is the patients in emergency rooms for non-emergency reasons. Because they cannot be turned away, people are driven to the emergency room which might be their only point to access the healthcare system.[118] Under the *Emergency Medical Treatment and Active Labor Act*, emergency rooms are required to treat patients who present until they are stabilized, regardless of their coverage.[119] Unfortunately, this is a particularly expensive access point to the system. Plus, some emergency rooms are still thought to be transferring patients or denying them care because they are not able to pay.[120] So not only is it expensive to the system but emergency rooms are only required to provide care to the point of medical stabilization: emergency departments are not charged with providing long-term care.[121]

Preventative care provides intervention before some chronic illnesses, like diabetes, develop.[122] If a doctor has access to a patient that is pre-diabetic, the doctor or a nurse practitioner can direct and monitor lifestyle changes like high fiber diets or regular exercise.[123] Heart disease is another example of chronic illness that is clinically known as preventable with proper intervention.[124] Not only is this better for a person to stay healthy, but late-stage medical procedures, like bypass surgery, are far more expensive than a trip to a primary care provider to facilitate discussion around healthy eating or prescribe inexpensive pharmacy interventions.[125] Short of preventing a chronic illness, early detection of illnesses can lower the risk of associated mortality and complications.[126] Tertiary care for chronic illness driven by the identification can stop progression of chronic illnesses as well.[127] Research has even shown preventative care or early detection, in terms of chronic illnesses that cannot be avoided, can still result in less time spent sick over a lifetime.[128] A 2008 study by the Commonwealth Fund found that 54 percent of chronically ill adults made at least one financially based decision about their chronic care.[129] This included decisions like, not fulfilling a prescription, not visiting a doctor even when sick, and not getting recommended care.[130] Making the decision to avoid primary and preventative care because

---

[117] Id.
[118] ARTICLE: The Inexorable Expansion of Medicaid Expansion, 39 N. Ill. U. L. Rev. 240 119 42 USCS § 1395dd
[119] 42 USCS § 1395dd
[120] ARTICLE: The Intentional Tort of Patient Dumping: A New State Cause of Action to Address the Shortcomings Cause of Action of the Federal Emergency Medical Treatment and Active Labor Act (EMTALA), 52 Am. U.L. Rev. 173
[121] Id.
[122] https://www.mayoclinic.org/diseases-conditions/type-2-diabetes/in-depth/diabetes-prevention/art-20047639
[123] Id.
[124] NOTE AND STUDENT WORK: A Cross-Cultural Analysis of Health Care Models-- Lessons Learned on the Importance of Localized Preventative Care in Reducing Chronic Disease, 12 J. Int'l Bus. & L. 443
[125] Id.
[126] https://www.ajpmonline.org/article/S0749-3797%2814%2900496-6/fulltext
[127] https://www.cdc.gov/pcd/issues/2019/18_0625.htm
[128] SYMPOSIUM: The New American Health Care System: Reform, Reformation, Or Missed Opportunity? ARTICLE: Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act, 159 U. Pa. L. Rev. 1873
[129] ARTICLE: The National Residency Exchange: A Proposal to Restore Primary Care in an Age of Microspecialization, 38 Am. J. L. and Med. 158
[130] Id.

of finances and coverage gaps can be detrimental to chronic patients.[131] Beyond helping chronic patients lead a better life, it is also less expensive for the healthcare system to stop, slow, or avoid complications from their illness.[132] The CDC measured just the 2016 medical costs to the healthcare system for chronic illness at over $1 trillion.[133] Any chance to reduce these direct costs by getting more patients to receive preventative care instead of acquiring higher severity chronic statuses could result in a large savings to the healthcare system. If chronic members can be managed through proper primary care, emergency visits and inpatient stays can be prevented which saves more money than it costs to provide the care.[134] The expansion population also often has other social determinants and behavioral health issues.[135] Coverage that puts those members in touch with primary care providers establishes a relationship and a point of care that can help the entire person. This may include linking with community care providers for food or housing that will allow lower long-term healthcare costs.[136]

V. Counterpoint: Long-Term Expense and Value

The amount of funding that states have for programs like Medicaid is simply not equal, because tax revenue is not equal.[137] Spending for legacy Medicaid programs and what they cover is reflective of that discrepancy.[138] The average spending per person in states that are in the highest third is $8,674, while the lowest third of states are only spending an average of $5,173 per person.[139] The same states do not have the same disparities in Medicare spending which means it is likely not a symptom of the illness burden of a state's residents.[140] If a state has such budgetary concerns as those lower spending states, what happens when the match from the federal portion lessens? Expansion plans have minimum coverage levels that will still have to be met.[141] This means they will have to find the funding for their 10 percent or more if legislation changes. Some state leaders have expressed a distrust that federal spending will stay at 90 percent.[142] Even at the 10 percent match though, states have asserted it will cost them hundreds of millions of dollars every year.[143] Estimates show the 10 percent for collective expansion states could cost $7 Billion.[144] For the average state, this means $100 Million.[145] This is especially important for states that have lower incomes because they already receive a higher matching rate for legacy Medicaid spending.[146] As a result of their current rates, the 90 percent matching rate is less of an incentive

[131] Id.
[132] https://www.cdc.gov/pcd/issues/2019/18_0625.htm
[133] Id.
[134] https://hbr.org/2020/01/managing-the-most-expensive-patients
[135] Cross-Sector Service Use Among High Health Care Utilizers in Minnesota After Medicaid Expansion | Health Affairs
[136] https://www.healthdatamanagement.com/opinion/payers-providers-jointly-benefit-from-sdoh-efforts
[137] ARTICLE: States of Inequality: Fiscal Federalism, Unequal States, and Unequal People, 108 Calif. L. Rev. 1531
[138] Id.
[139] Id.
[140] Id.
[141] PATIENT PROTECTION AND AFFORDABLE CARE ACT; ELDER JUSTICE ACT, 111 P.L. 148, Part 1 of 3, 124 Stat. 119, 121, 111 P.L. 148, 2010 Enacted H.R. 3590, 111 Enacted H.R. 3590
[142] ARTICLE: States of Inequality: Fiscal Federalism, Unequal States, and Unequal People, 108 Calif. L. Rev. 1531
[143] ARTICLE: States of Inequality: Fiscal Federalism, Unequal States, and Unequal People, 108 Calif. L. Rev. 1531
[144] https://www.commonwealthfund.org/publications/issue-briefs/2020/may/impact-medicaid-expansion-states-budgets
[145] Id.
[146] ARTICLE: States of Inequality: Fiscal Federalism, Unequal States, and Unequal People, 108 Calif. L. Rev. 1531

to expand.[147] Unfortunately, those with less incentives also will experience a higher burden to cover their portion.[148]

Florida, as one of the states to not expand, has Republican leadership that has said they would rather use the state money for job expansion.[149] Democratic representatives in Florida, like Nicolas Duran, however, have said it is because expansion was a major component of the ACA and therefore not something to which his Republican counterparts would agree.[150] Nebraska's Republican governor Pete Rickets opposed expansion for some of the same reasons.[151] He believed taking tax dollars from one group to report on them to another through entitlement programs was a flawed plan for a successful economy.[152] Rickets thought this was an attempt to grow an economy through the transfer of wealth which is not sustainable and will not produce jobs and prosperity for the future of Nebraska.[153]

Some state leaders who oppose expansion, have said that 10 percent of the costs may seem minor, but state governments that cannot fill budget gaps also cannot borrow to make their budgets operable like with the federal government.[154] In Louisiana, Governor Jindal estimated that expansion would cost state taxpayers $1.7 billion in the first ten years.[155] A third-party research report found that Louisiana would actually see savings over that time period.[156] Montana has similarly found that under the 100 percent and 95 percent matching funds from the federal government, the state is actually saving money, even as costs increase, and the new coverage has been a boost to jobs and the economy, helping offset the costs.[157] In an effort to continue expansion under the 90 percent match rate, Montana added a ballot question to approve a tax increase on cigarettes to pay for the 10 percent state portion.[158] The measure was defeated when tobacco companies lobbied against it; proving that even a small portion may not be easy to come by for some states.[159]

Another argument against Medicaid expansion is indirect. Opponents question whether it will result in more access to primary and preventative care for the expansion group. Medicaid payments are often lower than what commercial insurance might pay.[160] Some primary care providers could decline to take on Medicaid patients because of this which would make the coverage a moot point.[161] Also, there has been a known shortage of primary care providers for

[147] Id.
[148] Id.
[149] Expanding Medicaid would bring jobs, billions of dollars | Fort Myers Florida Weekly
[150] Id.
[151] ARTICLE: The Inexorable Expansion of Medicaid Expansion, 39 N. Ill. U. L. Rev. 240
[152] Id.
[153] ARTICLE: The Inexorable Expansion of Medicaid Expansion, 39 N. Ill. U. L. Rev. 240
[154] Id.
[155] Id.
[156] Id.
[157] Id.
[158] Id.
[159] Id.
[160] ARTICLE: The Inexorable Expansion of Medicaid Expansion, 39 N. Ill. U. L. Rev. 240
[161] ARTICLE: The Inexorable Expansion of Medicaid Expansion, 39 N. Ill. U. L. Rev. 240

decades, regardless of coverage.[162] Utah is trying to get ahead of that issue in a unique way.[163] The state has created legislation that would allow for providers to be reimbursed through any of their Medicaid ACOs at a minimum of the fee-for-service rates.[164] While these rates may not match commercial rates, this legislation at least allows a preserved minimum and a chance for an upside.

VI. Long-Term Cost Mitigation

Research of state budgets for those states choosing to expand, has shown a small or no overall increase in budget for this population.[165] Also, state leaders from both sides of the aisle were glad they had expanded.[166] States have enrolled more numbers than anticipated in the expansion pool, but because of the percentage being paid by the Federal government, it has not increased Medicaid costs in any substantial way.[167] Some of the reasoning for this, estimates show about 20 percent of the members covered under the expansion are not actually newly enrolled.[168] Instead, members shifted from other parts of legacy Medicaid, presumptive coverage for example, that were previously paid at a lower rate.[169] Presumptive coverage is given to those who may be eligible once the paperwork has been completed.[170] With a higher income threshold, they can enroll in the expansion population faster and maintain a higher rate of federal matching funds. Moreover, many states have said the enrollment increase and therefore budget increase for the population was either correctly predicted or even over-estimated.[171] The new enrollees also tend to be healthier than traditional Medicaid recipients.[172] On average, expansion enrollees account for 21 percent less spend than the traditional members.[173] The introduction of the expansion group has shown an overall per member reduction in Medicaid spend.[174] Access to preventative care will allow for high-value upfront services to avoid more costly services needed when there are complications from undiagnosed illnesses.[175] For those expansion members that are chronic, they are able to get interventions as discussed earlier in this paper. Even studies that show only a delay in chronic illness from prevention, and not a stop in progression, indicate that those costs of

[162] ARTICLE: The National Residency Exchange: A Proposal to Restore Primary Care in an Age of Microspecialization, 38 Am. J. L. and Med. 158
[163] 2018 Ut. HB 472, 2018 Utah Laws 468, 2018 Ut. Ch. 468, 2018 Ut. ALS 468
[164] Id.
[165] https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2018/03/26/do-states-regret-expanding-medicaid/
[166] Id.
[167] Id.
[168] https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2018/03/26/do-states-regret-expanding-medicaid/
[169] https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2018/03/26/do-states-regret-expanding-medicaid/
[170] https://www.medicaid.gov/medicaid/enrollment-strategies/presumptive-eligibility/index.html
[171] https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2018/03/26/do-states-regret-expanding-medicaid/
[172] https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/
[173] Id.
[174] Id.
[175] SYMPOSIUM: The New American Health Care System: Reform, Reformation, Or Missed Opportunity? ARTICLE: Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act, 159 U. Pa. L. Rev. 1873

treatment moved to later in life.[176] Costs for chronic complications that occur later in life are likely to fall under Medicare costs and the states will still avoid these costs.[177]

Not only do states seem happy with expansion they have made, but several states have added legislative out clauses to their expansion statutes and none of them have used the option.[178] Several Republican governors have even opposed legislation to repeal expansion under the ACA because they have seen benefits in their states.[179]

Expansion states have reduced medical debt for residents and a lower probability of bills in collections.[180] In fact, when comparing a continuously enrolled expansion group to those who dropped coverage, the debt climbed quickly for those in the latter group.[181] There was also a larger effect on personal finances, resulting in lower rates of evictions and bankruptcies which are costly to states in other ways.[182] This saves state budget dollars that would go toward housing assistance or even incarceration costs. Looking at just the data for South Carolina housing vouchers, as an example of what is being spent on housing for a non-expansion state, I found more than $155 Million was spent on vouchers in 2018.[183] This is not all dollars that would be saved but the numbers are staggering.[184] Expansion states also showed a higher rate of employment seekers.[185] Studies attributed this to people being healthier and having the financial security to seek better employment.[186] Therefore, some states showed higher tax revenue increases with little spend, since expansion meant an influx of federal funds to the state.[187] Beyond the increase in revenue, savings were shown in other areas of expansion state budgets.[188] Studies linked expansion to areas like community mental health, adult benefit waivers and healthcare for prisoners.[189]

In addition to personal finances, uncompensated care, and uncollectable bills are a drain on the medical system and state budgets.[190] Most states have laws about the veracity that hospitals are allowed to use in collecting payment for unpaid bills.[191] These laws mean that money is truly not accessible for the hospital. When examining almost five thousand hospitals in 2010, the

---

[176] Id.
[177] SYMPOSIUM: The New American Health Care System: Reform, Reformation, Or Missed Opportunity? ARTICLE: Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act, 159 U. Pa. L. Rev. 1873
[178] https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2018/03/26/do-states-regret-expanding-medicaid/
[179] Id.
[180] https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/
[181] Id.
[182] Id.
[183] https://www.cbpp.org/research/housing/national-and-state-housing-fact-sheets-data
[184] Id.
[185] https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/
[186] Id.
[187] Id.
[188] Id.
[189] https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/
[190] Id.
[191] NOTE: Using Community Benefits To Bridge the Divide Between Minnesota's Nonprofit Hospitals and Their Communities, 105 Minn. L. Rev. 2505

hospitals reported that unpaid bills made up 5.8 percent of their expenses for the year.[192] The payer mix change to more insured individuals was especially true in rural hospitals, which are often supported by states because communities can not afford to see them close.[193] The structure of the Emergency Medical Treatment and Active Labor Act (EMTALA) means sick people will eventually have one option for care in an emergency department.[194] Beyond that, the Consolidated Omnibus Reconciliation Act (COBRA) and most state laws against dumping patients that do not have the ability to pay, mean the facility is a place to seek help.[195] Not only does this mean a more expensive entrance to the system, as discussed earlier in this paper, but the burden of payment falls to the hospital or local governments.[196] The costs that cannot be absorbed directly by a hospital or local uncompensated care pool, get passed to other payers, like employer-based plans and Medicaid, through higher rates.[197] When examining US News & World Report's seven top-ranked hospitals after the first two years of the ACA, there was a clear benefit in revenue on this hospital expense.[198] These hospitals showed a reduction in charity care and free treatment of $142 Million.[199]

Some studies have shown that beneficiaries don't understand what their benefits and options for care are in the expansion states.[200] Explaining the benefits and access that are available may push members to less expensive primary care. An example of this, Americans get more MRI, CT scans, and PET scans than any other country.[201] These are expensive diagnostic tests that need a doctor who knows the patient to be thoughtful on need.[202] Expansion members become a part of the known and monitored system. Once members are on the radar of the system, they can become a part of managed care or value-based programs. The Accountable Care Organizations (ACO) being paid under Medicare's value-based program saved an estimated $739 Million in 2018.[203] This is an impressive enough performance that the Association of America's Health Insurance Plans (AHIP) support value-based programs among their members.[204] New York State is a great example of a Medicaid system that has used value-based care over fee-for-service payments and saved a tremendous amount of money to the system.[205] After showing savings, the

[192] https://www.modernhealthcare.com/article/20120106/BLOGS01/301069983/a-closer-look-at-hospital-write- offs
[193] https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/
[194] ARTICLE: Code Red: The Essential Yet Neglected Role of Emergency Care in Health Law Reform, 43 Am. J. L. and Med. 344
[195] ARTICLE: Cross-Subsidization in Hospital Care: Some Lessons From the Law and Economics of Regulation, 9 Health Matrix 1
[196] ARTICLE: Code Red: The Essential Yet Neglected Role of Emergency Care in Health Law Reform, 43 Am. J. L. and Med. 344
[197] ARTICLE: Cross-Subsidization in Hospital Care: Some Lessons From the Law and Economics of Regulation, 9 Health Matrix 1
[198] NOTE: Using Community Benefits To Bridge the Divide Between Minnesota's Nonprofit Hospitals and Their Communities, 105 Minn. L. Rev. 2505
[199] Id.
[200] https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/
[201] ARTICLE: The Regulatory Vision of Universal Healthcare in The United States: Strategic, Economic, and Moral Decision-Making, 21 U. Pa. J. Bus. L. 647
[202] Id.
[203] https://www.ahip.org/value-based-care-leads-the-way-to-lower-costs-and-better-quality/
[204] https://www.ahip.org/value-based-care-leads-the-way-to-lower-costs-and-better-quality/
[205] https://cma.com/about/success-stories/dsrip-value-based-payments-nys-medicaid-analytics

federal government was able to reinvest $8 billion in the state's system.[206] Instead of spiraling costs that are unknown until the uninsured patient enters the healthcare system of a state, often through the emergency department, expansion members can become a monitored part of a system and take advantage of some of the alternative payment models that are saving money.

VII. Overall Impact to States That Expanded

A review of studies from January of 2014 to January of 2020, showed there were positive impacts on the state in coverage levels, access to care, and the economy of the states that expanded.[207] There was some research to the contrary, showing no or negative impact in some areas, but the overwhelming majority was positive.[208] Research showed net financial benefits for expansion states through 2021.[209] On average, most states have generated enough savings within Medicaid to offset the costs of expansion.[210] As this paper discussed previously, some of the expansion members would have been covered under traditional Medicaid, and bringing them into the new population has shown a reduction in overall spend on Medicaid for states.[211] Some analysis has shown an average of a 4 percent to 5 percent reduction in spending for Medicaid.[212] This is a large portion of the 10 percent they will be expected to pay going forward and does not yet consider other forms of savings or revenue discussed in this paper. In fact, a recent income tax cut in Arkansas was linked to savings and revenues from Medicaid expansion.[213] Michigan actually created their expansion program with a clause that sunsets the program if they do not generate enough costs savings in the state budget to offset any added costs.[214] As a result, Michigan is watching progress closely and they estimate they are going to see sufficient savings at least through 2028.[215] Virginia did not choose to expand until 2017, so they made sure to place an insurance provider assessment tax so they could afford the state portion when needed.[216] Since Virginia realized larger than expected savings and this new revenue stream, they paid for the expansion twice and then some.[217] Virginia experienced costs of about $307 million but with savings and revenue they actually gained $803.6 million, netting the state $496.6 million for their budget.[218]

---

[206] Id.
[207] https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/
[208] Id.
[209] Id.
[210] https://www.commonwealthfund.org/publications/issue-briefs/2020/may/impact-medicaid-expansion-states-budgets
[211] https://www.commonwealthfund.org/publications/issue-briefs/2020/may/impact-medicaid-expansion-states-budgets
[212] Id.
[213] Id.
[214] Id.
[215] Id.
[216] Id.
[217] https://www.commonwealthfund.org/publications/issue-briefs/2020/may/impact-medicaid-expansion-states-budgets
[218] Id.

Data is still early for some studies, but analysis that was run from January 2014 to January 2020 was gathered so larger summary connections could be made.[219] Impact on quality can be more difficult to determine from data, but studies have shown favorable changes in expansion states that they can attribute to that effort.[220] One clear change is an increase in access to care which, as discussed earlier in this paper, means access to primary and preventative services.[221] Another quality measure used was self-reported health status.[222] This measure also showed positive directionality in most of the reviewed studies.[223] There are obviously issues with anything self-reported but this particular measure seems to speak to health status and general quality of life. Another factor reviewed and, in this case, largely shown to decrease, is all-cause mortality.[224] Other research shows access to medications and behavioral health services has improved.[225] Further, and more quantitatively than self-reported, quality of life has shown improvements with reductions in food insecurity, poverty, and home evictions.[226] More recent studies, conducted between February 2020 and March 2021, have confirmed and expanded on some of these results and explored other quality measures.[227] These studies also found a decline in mortality, but they also saw a positive access to care results for specific populations like those with cancer and chronic diseases.[228] This is especially pertinent in the current climate of COVID-19 because many of the chronic illnesses being considered were those that show a higher risk of COVID-19 symptom severity.[229] These studies also showed better access for people with diabetes which, as this paper discussed earlier, is a chronic illness that can have vastly different outcomes dependent on actions taken.[230] Another quality measure looked at was specifically for the disabled population that gained coverage through expansion.[231] There were only a few studies since it is such a unique topic, but some data showed that the disabled population had increased coverage opportunities and a link to this contributing to better mental health among their caregivers.[232] Demonstrating better quality for not just the actual member but beyond.[233] Expansion states also saw an increase in access and utilization by pregnant women and new mothers.[234] The data for these women shows lower rates of maternal mortality and fewer deliveries of babies that have a low birth weight.[235]

[219] https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/
[220] Id.
[221] Id.
[222] Id.
[223] Id.
[224] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.1380
[225] https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/
[226] Id.
[227] https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/
[228] Id.
[229] Id.
[230] Id.
[231] Id.
[232] https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/
[233] Id.
[234] https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/
[235] https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/

This is an important finding because low birth weights can cause severe complications to a newborn.[236] In fact, a 2001 study found the average length of stay for a low-weight newborn was almost 13 days and costs more than $15,000.[237] This is in contrast to the average for a healthy delivery which was less than a 2-day length of stay and about $600.[238] The data from that study on more complex low-weight newborns with respiratory complications are even more extreme with an average cost of $65,600.[239] Another unique view observed was around the testing for and treatment of HIV.[240] Studies showed higher testing rates for HIV but not higher positive rates.[241] They also found a higher quality of care for those who were HIV positive.[242] In other words, positive cases were caught sooner and providers were able to intervene early and at a high level of quality.[243] The final specific group that needs to be reviewed from these studies is that of the behavioral health population.[244] The data showed better access to care for both mental health and those with substance abuse disorder.[245] More important may be the type of care provided to those with substance abuse disorder.[246] There was better access to medication-assisted treatment and mental health treatments for their recovery.[247] This is important because if mental health or substance use disorder is left unchecked it can lead to complications and more severe problems like opioid abuse.[248] Taken as a whole, these are measurable and comparable data points that show quality has in fact been positively affected by the expansion of Medicaid.

---

[236]https://pubmed.ncbi.nlm.nih.gov/17606536/#:~:text=Preterm%2Flow%20birth%20weight%20infant,for%20specific%20respiratory%2Drelated%20complications

[237]https://pubmed.ncbi.nlm.nih.gov/17606536/#:~:text=Preterm%2Flow%20birth%20weight%20infant,for%20specific%20respiratory%2Drelated%20complications

[238]Id.

[239]https://pubmed.ncbi.nlm.nih.gov/17606536/#:~:text=Preterm%2Flow%20birth%20weight%20infant,for%20specific%20respiratory%2Drelated%20complications

[240] https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/

[241] Id.

[242] https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/

[243] Id.

[244] Id.

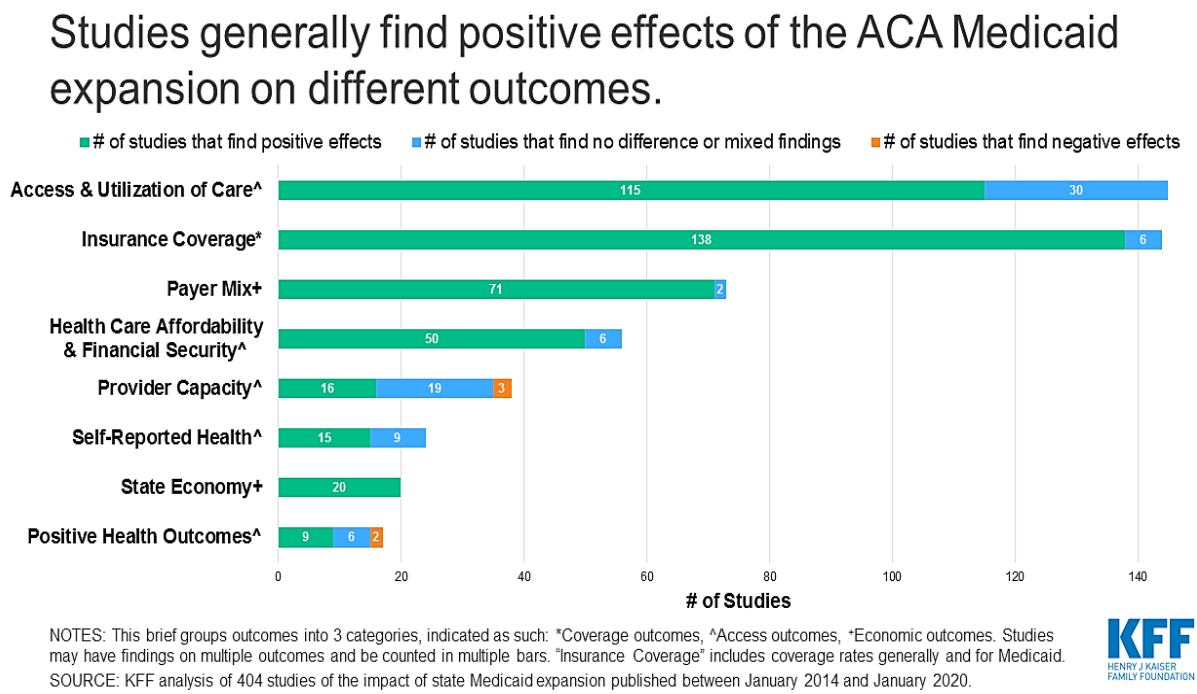
[245] Id.

[246] Id.

[247] https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/

[248] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2917238/

Figure 1



NOTES: This brief groups outcomes into 3 categories, indicated as such: *Coverage outcomes, ^Access outcomes, +Economic outcomes. Studies may have findings on multiple outcomes and be counted in multiple bars. "Insurance Coverage" includes coverage rates generally and for Medicaid.
SOURCE: KFF analysis of 404 studies of the impact of state Medicaid expansion published between January 2014 and January 2020.

KFF HENRY J KAISER FAMILY FOUNDATION

https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/

VIII. Conclusion

Pulling together all of the available data expansion states have experienced; a reduction of the uninsured population, an increase in preventative care, a decrease in adverse effects from chronic illness including death and expenses, and a decrease in uncompensated care pools and other social costs. This is all being done for a fraction of the medical costs incurred by the expansion population. States who have expanded Medicaid under the Affordable Care Act are showing positive results in their finances, better health quality levels for their residents, and positive outcomes on non-medical measures for the expansion population.[249] At this point, it

[249] https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review

should not be a political decision. All states who have not expanded should take advantage of the resources being offered and do what is best for the long-term benefits of their citizens. Medicaid expansion is the best long-term choice for all states.

About the Author, Shannon Garrison, MBA, MJ

Shannon Garrison has been in the healthcare industry for almost 20 years working for providers, payers, and government entities. She holds an MBA from Northeastern University and a Master's in healthcare law from Loyola University. As a consultant for the last 10 years, Shannon excels in developing strategies to support market growth through cost and quality targets and creating goals and actionable data templates to achieve Population Health Management. Her experience working for stakeholders across the spectrum of healthcare delivery and finance gives her a unique perspective that takes the complete industry needs into account.