

After the Supreme Court Decision: The Implications of Expanding Medicaid for Uninsured Low-Income Midlife Adults

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The Affordable Care Act *required* states to expand their Medicaid programs to cover more low-income people, including midlife adults.¹ However, a recent U.S. Supreme Court decision, while upholding the rest of the health reform law, effectively turned the mandate into a state *option*. This *Insight on the Issues* examines the Court's decision and how uninsured midlife adults in states that take up this option could benefit.

The ACA Medicaid Expansion

The Affordable Care Act (ACA)—the health reform law enacted in 2010—*required* all states to expand their Medicaid programs to cover individuals under age 65 with income at or below 138 percent of the federal poverty level (FPL).^{2,3} Beginning in 2014, states can receive 100 percent federal funding for covering these newly eligible individuals for three years. Beginning in 2017, the federal portion will gradually phase down to 90 percent by 2020.

Newly eligible individuals are those whose income does not exceed 133 percent of the FPL; who are between age 19 (or a higher age that the state has elected) and age 65; who are not pregnant; and who, as of December 1, 2009, were not eligible for full Medicaid benefits under a state plan or a waiver.^{4,5}

To enforce this new mandate, the ACA gave the Secretary of Health and Human Services authority to withhold *all* federal Medicaid funding for their *entire* program from states that did not take up the Medicaid expansion.

Supreme Court Challenge to the Medicaid Expansion

Twenty-six states challenged the constitutionality of the mandatory Medicaid expansion in the U.S. Supreme Court.⁶ The states collectively argued that the penalty for not complying with the mandate—the possible loss of all federal Medicaid funding for their entire programs—was a coercive use of federal power and therefore unconstitutional.

Accepting the coercion argument, the Court ruled that while federal lawmakers have the authority to expand Medicaid, they may not impose the threat of losing *all* federal Medicaid funding on states that elect not to do so.⁷ In making this ruling, the Court effectively created a state *option* to expand Medicaid in return for enhanced federal funding.

States at the Crossroads

It is now up to each state to decide whether to expand its Medicaid program to cover low-income people who are currently uninsured. There are several reasons why

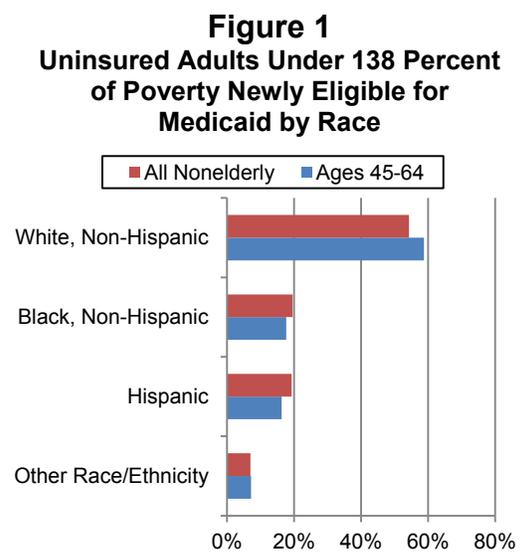
taking advantage of the Medicaid expansion can be a win-win proposition for uninsured low-income midlife adults and for states. Some of them are described below.⁸

The focus of this *Insight on the Issues* is on midlife adults. However, there are many reasons why states should take up the Medicaid expansion for low-income uninsured adults of all ages. These have been well documented elsewhere.⁹

Characteristics of Midlife Adults Likely to Benefit from the Medicaid Expansion

About 4 million low-income adults ages 45–64 who currently lack insurance would gain access to Medicaid under the expansion.¹⁰ In Table 1, we show how many uninsured midlife adults would gain access to Medicaid in each state.¹¹

Approximately 60 percent of those in this group are non-Hispanic whites. However, non-Hispanic blacks and Hispanics represent a significant proportion of those who would gain access to insurance through a Medicaid expansion (approximately 18 and 16 percent, respectively)¹² (figure 1).



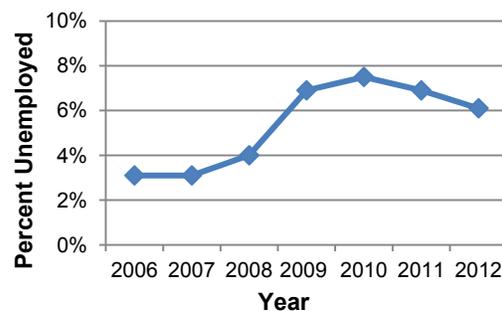
Source: AARP analysis of Urban Institute estimates based on analysis of American Community Survey Records, 2008, 2009, and 2010 (adults only).

The majority of those in this age group who would gain access to coverage through Medicaid are single adults with no dependents (52 percent), and over half (53 percent) are women. Most have a high school education or less (approximately 68 percent).¹³

Millions of Uninsured Midlife Adults Would Gain Access to Care at a Time in Their Lives when They Can Most Benefit

Between 2006 and 2011, there was a 15 percent increase in uninsured adults ages 45–64, going from 14.2 percent in 2006 to 16.3 percent in 2011.¹⁴ This increase reflects, in part, the rise in unemployment during the recent economic recession (figure 2) and the associated lack of employer-provided health insurance coverage. Once they become unemployed, older workers are out of work longer than their younger counterparts, with an average duration of unemployment in January 2013 of 43.8 weeks (compared to 32 weeks for the younger age group).¹⁵

Figure 2
U.S. Unemployment Rate Age 45–64, 2006–2012



Source: AARP calculation from the Bureau of Labor Statistics, Labor Force Statistics from the Current Population Survey Annual Averages, 2006–2012 (numbers in thousands).

These uninsured adults would likely benefit from an expansion, because the prevalence of chronic conditions increases during midlife. This is especially the case for those with low incomes.¹⁶ We estimate that 11 percent

of the midlife adults who would gain access to Medicaid would be in fair to poor health.¹⁷

Uninsured people with chronic illnesses are less likely to receive the care they need to manage their health conditions than their insured counterparts. They are also more likely to have worse clinical outcomes when they finally do receive treatment for their conditions—typically in expensive emergency rooms.¹⁸

Having Medicaid would give uninsured low-income adults who are in their middle years access to the treatments and services they need to help them manage, monitor, and better control their chronic conditions. Of the 4 million uninsured midlife adults who would gain access to Medicaid, 1.5 million are employed. The security of Medicaid coverage would help them maintain employment. Midlife adults who are unemployed because they are in poor health would benefit from Medicaid coverage. The ability to improve their health status could increase their ability to re-enter the labor force.

- **States that invest in the health of uninsured low-income adults during their middle years might realize significant benefits when these individuals become eligible for Medicare.** Most people become eligible for Medicare once they reach age 65. Low-income adults who are on Medicare are also likely to become dual eligibles—which means they will depend on Medicare for their primary and acute health needs (hospital, physician services, laboratory and x-ray services) *and* on Medicaid for help with their Medicare cost sharing and their long-term services and supports (LTSS) needs.

Traditionally, dual eligibles have been among the sickest, poorest, and costliest Medicaid beneficiaries, many of whom end up depending on

the program to pay for LTSS, like home- and community-based LTSS, personal care, home health care, and institutional long-term care.¹⁹

As the primary payer for LTSS for low-income adults, states have a unique opportunity to expand their Medicaid programs to give low-income midlife adults—who tend to have multiple chronic illnesses—access to care that has the potential to improve or maintain their health status, long before their conditions deteriorate to the point where they are likely to need costly Medicaid-financed LTSS, in addition to their Medicare benefits.

- **States that expand Medicaid early can realize the biggest savings.** States that expand their programs beginning in 2014 will receive greater financial advantage than those that expand in later years for two reasons. First, the federal government will pay 100 percent of the cost of care for the expansion group until the end of 2016. Second, for a population that is likely to have “pent-up” demand for health care,²⁰ costs associated with getting their health conditions under control will be covered 100 percent by federal dollars between 2014 and the end of 2016.²¹ For states that offer coverage in 2014, by the time they are required to begin paying a portion of the expansion costs in 2017—which is phased in over four years and does not exceed 10 percent of the total cost of the coverage—beneficiary costs should be considerably less.²²
- **Expanding Medicaid will give uninsured midlife adults access to potentially lifesaving preventive and screening services and could reduce disparities.** People without health insurance are far less likely to access recommended preventive and screening services—such as flu shots, cholesterol

screening, mammograms, and colorectal cancer screening—than their insured counterparts.²³ The ability to access prevention and health screenings means that people can avoid contracting certain illnesses and/or have their conditions diagnosed and treated much earlier—when they are less costly to a state’s uncompensated care system. For example, colorectal cancer is largely preventable through screenings to detect noncancerous polyps. Experts recommend that adults begin screening at age 50. Yet, many adults forgo the test because of cost. Having access to Medicaid would eliminate this barrier for millions of low-income adults, and help states avoid the high uncompensated care costs associated with treating advanced cancers.

Because Medicaid requires beneficiaries to pay only nominal cost sharing when they receive services, states that take up the expansion may increase the likelihood that low-income people will take advantage of recommended preventive and screening services. In addition to providing access to prevention and screening through a Medicaid expansion that is largely federally financed, states can reduce their financial exposure by an additional percentage point by taking advantage of a provision in the ACA that allows them to elect an option to *eliminate* cost sharing for certain preventive and screening services.²⁴ While this may not seem like much of a saving, states should carefully consider the health and financial consequences of not maximizing opportunities to provide access to prevention and screening services.

Finally, taking up the Medicaid expansion could have a positive impact on reducing disparities among midlife uninsured adults. Compared to whites, non-Hispanic blacks are

8 percentage points less likely to have health insurance coverage; and Hispanics are 19 percentage points less likely to have such coverage. An Urban Institute study found that the Medicaid expansion coupled with premium tax credits available to people through health insurance marketplaces could reduce these disparities by more than half for non-Hispanic blacks, and by almost one-quarter for Hispanics.^{25,26}

Racial and ethnic disparities in the use of prevention and screening services persist notwithstanding health insurance status. However, studies among African Americans and Hispanics find an association between health insurance and increased receipt of preventive care. These studies also find that insurance status increases the likelihood of having a regular source of care, which also improves one’s chances of receiving preventive services.²⁷ Thus, expanding Medicaid could have a positive impact on reducing disparities in the use of prevention and screening services.

- **Making Medicaid available to low-income adults who are uninsured during their middle years can help ensure that they are able to meet basic needs as they age.** A study of low-income uninsured adults in Oregon found that those who received Medicaid experienced more financial security than their uninsured counterparts. Those with Medicaid were 40 percent less likely to report borrowing money or skipping payments on other bills because of medical expenses. They were also 25 percent less likely to have unpaid medical bills that were sent to a collection agency.²⁸ These findings suggest that having Medicaid is critical to ensuring that low-income adults are able to meet their basic needs.

Conclusion

The option to expand Medicaid gives states a cost-effective way to improve the health status of uninsured low-income people at a time in their lives when they are most likely to be developing chronic health conditions such as diabetes, heart disease, and stroke—conditions that, left untreated, can result in costly deteriorations in health status and premature death for these individuals, and millions of dollars in uncompensated care costs for states.²⁹ In fact, Medicaid expansions in three states—Arizona, Maine, and New York—were associated with significant decreases in mortality, especially among vulnerable populations, compared with neighboring states that did not expand Medicaid coverage.^{30,31} In addition, hospitals are facing significant cuts to their disproportionate share hospital (DSH) payments—federal dollars that help fund uncompensated care for the uninsured. These hospitals stand to realize significant gains if states expand

Medicaid, thus reducing the burden of uncompensated care at a time when hospitals' funding for such care will be substantially reduced.³²

In addition to saving lives and state uncompensated care dollars,³³ states that expand Medicaid are likely to experience significant economic benefits, including job growth and increased income and state tax revenues.^{34,35} For example, in 2009, 6 percent of full-time jobs in Arkansas were generated by the Medicaid program. In addition, Arkansas officials estimate that the state economy will be hundreds of millions of dollars larger if it opts to expand Medicaid, resulting in a positive impact on state tax revenue.³⁶

In deciding whether to expand their Medicaid programs, states should carefully consider the positive impact of an expansion on the health, well-being, and longevity of their low-income citizens who are in their middle years and find themselves uninsured.

Table 1
Current Uninsured under 138% FPL that
Gain Medicaid Eligibility Under the Expansion

	Ages 45–64	All Nonelderly
Total	4,003,647	13,804,538
Alabama	80,144	298,637
Alaska	11,826	44,762
Arizona	18,642	64,558
Arkansas	53,081	200,841
California	535,567	1,756,185
Colorado	63,723	201,770
Connecticut	25,667	81,966
Delaware	2,144	6,801
District of Columbia	5,105	16,979
Florida	379,327	1,164,916
Georgia	173,952	629,912
Hawaii	12,438	37,960
Idaho	26,398	97,249
Illinois	152,989	503,581
Indiana	85,562	330,931
Iowa	25,172	88,463
Kansas	30,442	118,002
Kentucky	69,316	256,296
Louisiana	88,954	305,558
Maine	14,187	40,170
Maryland	47,298	160,402
Massachusetts	23,106	80,869
Michigan	146,468	520,246
Minnesota	34,611	122,626
Mississippi	57,697	210,747
Missouri	86,078	320,084
Montana	20,893	58,212
Nebraska	19,173	71,361
Nevada	43,991	139,331
New Hampshire	13,876	43,172
New Jersey	83,329	269,817
New Mexico	41,287	132,356
New York	38,382	127,308
North Carolina	146,882	514,026
North Dakota	5,870	21,804
Ohio	163,170	540,993
Oklahoma	57,220	212,255
Oregon	66,155	224,477
Pennsylvania	132,543	459,582
Rhode Island	9,543	32,455
South Carolina	85,390	272,836
South Dakota	12,149	40,057
Tennessee	108,785	334,731
Texas	427,566	1,659,778
Utah	21,414	95,883
Vermont	*	774
Virginia	89,278	315,541
Washington	75,444	270,854
West Virginia	32,144	113,900
Wisconsin	51,841	168,650
Wyoming	7,429	23,878

Source: ACS 2008–2010, Weighted to 2012

* Very small sample size.

Endnotes

¹ For purposes of this *Insight on the Issues*, midlife adults refer to adults ages 45 to 64.

² The law technically requires states to cover all individuals with income at or below 133 percent of the federal poverty level. But because the law eliminates historical income disregards for these new groups and establishes a new across-the-board 5 percent income disregard, the effective income eligibility threshold is 138 percent of the FPL. L. Flowers, *Health Reform Provides New Federal Money to Help States Expand Medicaid* (Washington, DC: AARP Public Policy Institute, 2010).

³ The federal poverty guidelines (commonly referred to as the federal poverty level or FPL) are one version of the federal poverty measure. They are issued each year in the *Federal Register* by the Department of Health and Human Services (HHS). The guidelines are used for administrative purposes—for instance, to determine financial eligibility for certain federal programs. U.S. Department of Health and Human Services, *2012 HHS Poverty Guidelines, Federal Register Notice*, January 26, 2012, <http://aspe.hhs.gov/poverty/12poverty.shtml>.

⁴ L. Flowers, *Health Reform Provides New Federal Money*.

⁵ States that were already providing comprehensive health coverage to parents and childless adults with income up to 100 percent of the FPL when the ACA was enacted are called “expansion states” and will initially receive less federal assistance than states that did not previously extend such coverage. However, by 2019, the federal Medicaid assistance percentage (FMAP) for these states will be equal to the enhanced FMAP available for the newly eligible adults.

⁶ The states were Alabama, Alaska, Arizona, Colorado, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin, and Wyoming. *A Guide to the Supreme Court’s Decision on the ACA’s Medicaid Expansion* (The Henry J. Kaiser Family Foundation, August 2012).

⁷ Nat’l Fed’n of Indep. Bus. v. Sebelius, 567 U.S. ___, 132 S. Ct. 2566 (2012).

⁸ Other reasons exist. This *Insight on the Issues* presents those that are most relevant to midlife uninsured adults.

⁹ See, for example, J. Perkins, *50 Reasons Medicaid Expansion is Good for Your State* (Carrboro, NC: National Health Law Program, 2012).

¹⁰ Urban Institute estimates based on three-year merge of data from the American Community Survey, (2008–2010), weighted to 2012.

¹¹ Estimates in Table 1 are based on the 2008, 2009, and 2010 ACS combined. We computed MAGI based on the detailed income components available on the survey and used the HHS Poverty Guidelines to determine those with family MAGI below 138 percent of poverty. Immigration status was imputed based on the methodology of Jeff Passel. Current eligibility for Medicaid was assessed using a model developed at the Urban Institute that takes into account each state’s eligibility rules and groups people into the units that would be used to determine eligibility.

¹² Urban Institute estimates based on analysis of the ACS, 2008–2010 records.

¹³ Urban Institute estimates based on analysis of the ACS, 2008–2010 records (adults only).

¹⁴ AARP calculation based on Current Population Survey Data from March 2006 to March 2012, February 4, 2013.

¹⁵ S. Rix, *The Employment Situation January 2013: Jobs Added to the Economy but Unemployment Holds Steady* (Washington, DC: AARP Public Policy Institute, February 2013).

¹⁶ National Center for Health Statistics, *Health, United States, 2011: With Special Feature on Socioeconomic Status and Health* (Hyattsville, MD: National Center for Health Statistics, 2012).

¹⁷ Urban Institute estimates based on three-year merge of data from the ACS (2008–2010) (adults only).

¹⁸ Institute of Medicine, *Care without Coverage: Too Little, Too Late* (Washington, DC: National Academy Press, 2002).

¹⁹ K. Young et al., *Medicaid's Role for Dual Eligible Beneficiaries* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, April, 2012).

²⁰ The Henry J. Kaiser Family Foundation, *Expanding Medicaid to Low-Income Childless Adults under Health Reform: Key Lessons from State Experiences* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, July 2010).

²¹ L. Flowers, *Health Reform Provides New Federal Money*.

²² Ibid.

²³ Institute of Medicine, *Care without Coverage*.

²⁴ L. Flowers and W. Fox-Grage, *Health Reform Law Creates New Opportunities for States to Save Medicaid Dollars* (Washington, DC: AARP Public Policy Institute, 2011).

²⁵ Health insurance marketplaces are central locations where qualified individuals (e.g., those without access to other health insurance coverage) can go to purchase coverage. Premium tax credits are available in the marketplace to help make health insurance premiums more affordable to qualifying individuals. For more information, see G. Smolka and S. Sinclair, *The Creation of American Health Benefit Exchanges* (Washington, DC: AARP Public Policy Institute, March 2011).

²⁶ L. Clemans-Cope, G. M. Kenney, M. Buettgens, C. Carroll, and F. Blavin, "Health Reform Could Greatly Reduce Racial and Ethnic Differentials in Insurance Coverage," *Health Affairs* 31, no. 5, 920–930.

²⁷ Institute of Medicine, *Care without Coverage*.

²⁸ K. Baicker and A. Finkelstein, "The Effects of Medicaid Coverage—Learning from the Oregon Experiment," *New England Journal of Medicine* 365, no. 8 (August 25, 2011).

²⁹ Uncompensated care is medical care received, but not fully paid for, either out-of-pocket by individuals or by a private or public insurance payer. The cost of unpaid care is estimated by using the benchmark of what would have been paid for the services by private insurance. J. Hadley and J. Holahan, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending? Issue Update* (Washington, DC, Kaiser Commission on Medicaid and the Uninsured, 2004).

³⁰ Adults ages 35 to 64, minorities, and residents of poor counties experienced the greatest reductions in mortality. B. Sommers, K. Baicker, and A. Epstein, "Mortality and Access to Care among Adults after State Medicaid Expansions," *New England Journal of Medicine* 367, no. 11 (September 13, 2012):1025–34.

³¹ University of Arkansas Sam M. Walton College of Business, *The Economic Impact of Medicaid Spending in Arkansas* (Fayetteville, AR: University of Arkansas Sam M. Walton College of Business, May 2010).

³² The DSH cuts were premised on an expected increase in insurance coverage through the health insurance exchanges and expanded Medicaid eligibility. If that careful balance is disrupted because states do not expand their programs, millions will remain uninsured and continue to rely on safety net hospitals for care at a time when the hospitals will see their funding for uncompensated care diminish.

³³ It is estimated that states and localities will experience \$18 billion in Medicaid savings on uncompensated care. J. Holahan et al., *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, November 2012).

³⁴ C. Marks and R. Rudowitz, *The Role of Medicaid in State Economies: A Look at the Research* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2009).

³⁵ Some argue that the economic gains associated with expanding Medicaid are diminished by the fact that individuals who were eligible but not enrolled in the program pre-expansion (mostly children), will be identified and enrolled in Medicaid. However, research suggests that other ACA policies will drive this phenomenon whether or not states take up the expansion. This same research found that states are likely to realize net savings from the expansion, even with new enrollment of those who were previously eligible but not enrolled. J. Holahan et al., *The Cost and Coverage Implications of the ACA Medicaid Expansion*.

³⁶ Testimony of Andrew Allison, Ph.D. Director, Division of Medical Services, Department of Health Services, State of Arkansas, before the Committee on Energy and Commerce Subcommittee on Health, U.S. House of Representatives, “State of Uncertainty: Implementation of PPACA’s Exchanges and Medicaid Expansion,” December 13, 2012, accessed at <http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/Hearings/Health/20121213/HHRG-112-IF14-WState-AllisonA-20121213.pdf>.

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