SHARP
State Healthcare Access Research Project

State Healthcare Access Research Project:

Toolkit: ACA Implementation in Illinois
Part I: The Medicaid Expansion

MEDICAID & THE AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act (ACA) extends Medicaid, via the states, to individuals living below 133% of the federal poverty level (FPL).[1] Pursuant to the Supreme Court's reading of the law, the Department of Health and Human Services (HHS) cannot revoke existing federal medical funding for failure to comply, making the provision unenforceable.[2] In other words, states that expand Medicaid pursuant to the law will receive substantial increases in federal funding (covering 90-100% of newly eligible beneficiaries indefinitely), and those that do not expand will not experience any change in Medicaid funding.

There is strong empirical evidence that the federal funding accompanying the expansion will significantly improve not only individual and public health, but also the fiscal stability of the state of Illinois. As elected officials move forward to implement the ACA, the following issues should be considered.

MEDICAID & INDIVIDUAL AND PUBLIC HEALTH IN ILLINOIS

- **Chronic Illness and Disability** – Access to preventive and regular care reduces morbidity and mortality associated with chronic illnesses and disabilities. Not only can screenings and precautionary steps often prevent onset of disease (e.g., diabetes, hypertension, and cardiovascular diseases) but early diagnosis and treatment can also significantly reduce the severity of prognoses (e.g., asthma and many cancers). Habilitative and rehabilitative services reduce utilization of high cost inpatient and institutional care, maximizing independence and productivity.

- **Infectious Disease** – The public health benefits of expanded Medicaid translate directly to the safety and security of all Illinoisans. Access to screening and treatment reduces the spread of disease by providing a cure or reducing infectiousness. For example, continuous and comprehensive treatment of HIV not only improves the health of the individual, but also has been shown to reduce the likelihood of transmitting the virus by 96%.[3] Nearly 33,000 Illinoisans are living with HIV and aware of the diagnosis, yet 47% are not connected to any treatment.[4] Expanding Medicaid to cover individuals living below 133% FPL would significantly alleviate the state's HIV epidemic.

- **Disparities** – Health disparities (health differences closely linked to social or economic disadvantages) are a national challenge, but particularly stark in Illinois, which ranks 25th in the nation for its proportion of uninsured residents.[5] Low-income individuals have higher rates of heart disease and diabetes and consistently shorter life expectancies than their wealthier counterparts.[6] Race also plays a role in health outcomes: in Illinois, African-Americans are significantly more likely to die of diabetes or cardiovascular disease than whites and more than twice as likely to die before age one.[7,8,9] One of several reasons for these disparities is the restrictive Medicaid eligibility standard in Illinois, leaving most low-income individuals without access to care (14% fewer African-American women in Illinois receive prenatal care in the first trimester of pregnancy than white women).[10] Reducing disparities has been a federal target since the turn of the century, and is part of the ACA's design (e.g., the Medicaid expansion provision). Access to health insurance is a fundamental determinant of health outcomes (e.g., Medicare has reduced disparities among the elderly by providing individuals with similar coverage regardless of income or ethnicity). Illinois would benefit significantly from the Medicaid expansion when it comes to improving health equity; federal money would fund a substantial decline in disparities that detract from economic productivity and exacerbate high levels of poverty across the state.

MEDICAID & FISCAL STABILITY

- **Hospital Solvency** – Hospitals are required by law to stabilize any Illinoisan in need, regardless of ability to pay. Because of the high proportion of uninsured residents, this amounts to millions of dollars in uncompensated care ($4.2 million in 2011).[11] Anticipating that this number will fall as uninsured individuals purchase private coverage or enroll in Medicaid, the ACA incrementally reduces federal payments that currently help hospitals offset these costs (known as disproportionate share hospital funds).[12] Reducing these payments to hospitals presumes substantial savings that would incur only by approaching near universal coverage. For example, under full ACA implementation, in the first five years of expanding coverage, Illinois hospitals would save over $1.7 billion on uncompensated care.[13] Thus, if Illinois forgoes the Medicaid expansion, its hospitals will face severe deficits as they continue to treat a high volume of uninsured residents (over

630,000 uninsured Illinoisans live below 100% FPL and thus are not eligible for federal subsidies to purchase coverage on an exchange).[14] Without federal reimbursements for this care, hospitals will pass the cost onto privately insured patients, inflating premiums. Worse still, some small hospitals (e.g., in rural areas) will not be able to offset these costs, and may be forced to close, leaving entire communities without access to care (not to mention eliminating hundreds of jobs).[15]

- **Federal Funding** – Illinois stands to be a large beneficiary of the federal dollars associated with the expansion. Illinois has a proportionately comparable rate of uninsured to the national average, but has a large population, making its uninsured pool substantially large (15% of its population, or 1.9 million Illinoisans); the expansion would cover 45% of the uninsured (over 840,000), almost entirely with federal dollars.[16,17] In fact, the cost to Illinois will never exceed 10% and the state will experience economic growth from the influx of additional federal funds. Indeed, prior Medicaid expansions have created jobs and increased consumer spending (spurring demand for healthcare workers and alleviating medical debt, thereby generating increased disposable income).[18] Thus, it is important to consider the net fiscal effect of expanding Medicaid, rather than merely the isolated cost of covering new beneficiaries. Moreover, if Illinois declines federal expansion funds, its residents will ultimately subsidize the cost of coverage in states that do accept the money, via federal taxation. Voters will be particularly attuned to this point.

- **Net State Savings** – The cost of the state share of newly eligibles (10%) will be offset by the savings realized in reduced spending on uncompensated care. Not only will the cost of "free" emergency care to the uninsured (funded by Illinois taxpayers) fall drastically with nearly universal coverage, but the overall cost of treatment will decline as well, as Illinoisans benefit from preventive services available free of charge. Indeed, in the first five years of expanding Medicaid, Illinois would realize net savings of $127 million.[13]

CONCLUSION

Expanding Medicaid pursuant to the ACA presents Illinois with a tremendous opportunity to reduce state spending, improve public health, and keep healthcare providers and hospitals solvent. The state has already demonstrated forward movement in securing cost-effective care for low-income residents that both improves health outcomes and reduces the fiscal burden on providers and the state (e.g., offering a robust range of optional benefits and expanding Medicaid to additional residents living below 100% FPL). Implementing the ACA's Medicaid expansion option would further benefit the state's health and healthcare system, in the spirit of these steps already taken.

1 Patient Protection and Affordable Care Act (ACA), 42 U.S.C. § 2001(a) (2010).
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4 Illinois Dept. of Pub. Health, HIV Surveillance Unit (Dec. 2011).
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6 Secretary's Advisory Committee On National Health Promotion And Disease Prevention Objectives For 2020, Phase 1 Report: Recommendations For The Frame work And Format Of Health People 2020, Dept. Health & Human Services (2008).
7 StateHealthFacts.org, Individual State Profiles, Illinois: Number of Diabetes Deaths per 100,000 Population by Race/Ethnicity, 2008, http://www.statehealthfacts.org/profileind.jsp?ind=76&cat=2&rgn=15 (last visited Sept. 11, 2012).
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11 Fredric Blavin, Matthew Buettgens, & Jeremy Roth, *State Progress Toward Health Reform Implementation: Slower Moving States Have Much to Gain*, Urban Institute & Robert Wood Johnson Foundation (2012).
12 ACA § 2551(a).
13 Matthew Buettgens, Stan Dorn, & Caitlin Carroll. *Consider Savings as Well as Costs: State Governments Would Spend at Least $90 Billion Less with the ACA than without it from 2014-2019*, Urban Institute & Robert Wood Johnson Foundation (2011).
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15 Andrea Kovach, *Expanding Medicaid: the Choice is Clear*, Shiverbrief, July 10, 2012.
16 StateHealthFacts.org, Individual State Profiles, Illinois: Health Insurance Coverage of the Total Population, states (2009-2010), U.S. (2010), http://www.statehealthfacts.org/profileind.jsp?ind=125&cat=3&rgn=15 (last visited Sept. 11, 2012).
17 StateHealthFacts.org, Individual State Profiles, Illinois: Health Insurance Coverage of Adults (19-64) with Incomes under 139% of the Federal Poverty Level (FPL), states (2009-2010), U.S. (2010), http://www.statehealthfacts.org/profileind.jsp?ind=779&cat=3&rgn=15 (last visited Sept. 11, 2012).
18 Jonathan Gruber, *Medicaid* (Nat'l Bureau of Econ. Research, Working Paper No. 7829, 2000).

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