Challenges facing Medicaid expansion in the US
Douglas Noble, Nikola Biller-Andorno, Jason M Sutherland, and Matthew Anstey give an international perspective on some of the key battlegrounds that could make or break the expansion of Medicaid

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The Patient Protection and Affordable Care Act (ACA) 2010 received two major boosts last year with the upholding of most of the law as legal by the Supreme Court, and the re-election of President Barack Obama. As 2013 proceeds, critical parts of the law are being implemented across the United States.

At the heart of the ACA is the federal objective of expanding insurance coverage. A substantial proportion of expanded health insurance is anticipated to be achieved by optional state level expansion of Medicaid (the government plan for poor and disabled people). Currently, there are restrictions on eligibility that vary from state to state. Extending Medicaid to those whose income is below 138% of the federal poverty level is projected to increase eligibility for under 65 year olds by about 12 million.\(^1\)

International comparisons

This potentially massive expansion across 50 diverse states is reminiscent of major changes in health systems in Europe, Canada and the Antipodes, since the end of the second world war: the National Health Service in Britain introduced a single payer single provider system for all citizens in 1948;\(^2\) in Switzerland mandatory health insurance for the entire population was introduced with the Federal Law on Health Insurance in 1994;\(^3\) the Australian government introduced a national health insurance scheme in 1975 (called Medibank at the time, and now called Medicare);\(^4\) and provincial healthcare systems in Canada have all provided first-dollar coverage of medical and hospital services since 1971.\(^5\) These Federal programs have resulted in substantial benefits for these countries’ populations, facilitating access to state-of-the-art care, and, importantly, strengthening the notion of healthcare as a human right rather than a commodity. Medicaid expansion plus the other coverage expansion provisions in the ACA have the potential to have similar benefits. However, its implementation faces several problems. Below, we focus on particular challenges associated with its expansion.

Federal v state tension

The ACA reignites the fundamental tension between federal and state decision making in the US.\(^6\) The federal government has always paid at least half of the cost of Medicaid—the federal share ranges up to 70% in some states—but it will bear 100% of the Medicaid expansion in the first few years in most states. Even so, not all states are choosing to expand Medicaid. At the time of writing, 22 US state governors plan to implement the expansion of Medicaid, with 17 governors refusing to participate and eight unclear/undecided states.\(^7\)

Texas’s Republican governor, Rick Perry, in his comments on opposition to Medicaid expansion on 1 April 2013, articulates the deep suspicion of federalism: “Texas doesn’t need another mandate, but the flexibility to care for our own in a manner that makes sense both effectively and financially.”\(^8\)

Texas is the state with the highest number of uninsured people, at 24.6% of the population.\(^9\)

Experience of tension between state and federal involvement in healthcare is not unique to America. For example, in the United Kingdom the National Health Service in Scotland had additional initial legislation and is controlled from Edinburgh, not London.\(^10\) In Australia the federal government funds universal benefits schemes for outpatient services and pharma, while the states provide the services and funds for public and psychiatric hospitals and public health. This leads to tension and cost shifting between the states and federal government.\(^11\)
In Switzerland, responsibility for health is shared between state, cantons, and municipalities; each of the 26 cantons has its own healthcare system. Though federal dollars associated with expansion, the political and financial responsibilities can render the implementation of reforms difficult and makes the system hard to steer. In Canada, even though funding is derived from provincial and federal governments, the organization and delivery of healthcare are provincially based. This split in powers leaves the Canadian healthcare system similarly diverse, and open to ongoing squabbles regarding adequate levels of federal contributions to healthcare funding. In this environment, the federal government has few levers to encourage nationwide healthcare reforms unless they are coupled with substantial new funding commitments.

The fact that federalism is emerging as a central issue in US healthcare reform is not surprising to countries that have trodden this path previously, but it is likely to be the major deciding factor in whether Medicaid becomes more available to poor people.

Internal state politics

Internal politics within states will also likely take a key role, particularly the pressures exerted by hospital lobbyists, who may be more influential than advocates for the poor. Between 2014 and 2020 the Federal government will gradually reduce the “disproportionate share” that goes to hospitals that treat large numbers of low-income patients. Thus, in states that do not adopt, hospitals may experience declines in their revenues even as the numbers of low-income patients does not shrink. How long state governors like Rick Perry can fend off pressure from their own private healthcare industry is questionable, and it may drive some Republican controlled states to accept the federal dollars associated with expansion. And with Massachusetts, there is an example of a state that in fact applied similar reforms before those stipulated by the ACA while governed by a Republican (Mitt Romney). Yet, ideology can be slow to change. Despite Republican controlled states like Texas having the highest need for change because of its large number of uninsured residents, federal involvement in Medicaid may be one step too far.

Implications of a fragmented system

The US healthcare system does many things well—particularly innovation with enthusiasm. At the same time, the deep complexity and fragmentation of the system is overwhelming. Add to this, 50 different states with diverging perspectives and their own government, and the expansion of Medicaid seems daunting. Parallels in Europe also suggest that many countries are seeing a shift towards fiscally conservative politics in face of economic pressures. Whether this move will be felt in the US, and whether it will influence the healthcare debate is less certain, especially with the re-election of a Democrat president. The balance, though, is finely poised, such that states that have not implemented by the next presidential election in 2016 may miss their chance for federal funding for expansion.

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