State response to funding challenges for expanded Medicaid program under Affordable Care Act

The Affordable Care Act also known as Obama Care is an act that was enacted in 2010. President Barack Obama's campaign to run for presidency was based off of his Obama Care plan. This law provides subsidies that lower costs for households with incomes that are very low. Medicaid was supposed to expand the eligibility of insurance, especially for adults. Under the law, parents would have had to give Medicaid to parents that were at or below 138 percent of the federal poverty level. Customers only pay for some and the government will pay for the rest. People without children are typically ineligible to receive Medicaid benefits with only nine states allowing people to receive Medicaid benefits with no children. The Affordable Care Act would have made it so that the federal government would have covered the full cost of Medicaid to each state. There have been challenges to the funding to expand this program to get more people insured under it.

The Affordable Care Act allowed states to expand the benefits or lower benefits and gave some freedom to the states to decide which people would receive certain benefits. Under this plan you can have your own private insurance. You cannot be denied for a preexisting condition which was President Obama's reason for passing Obama Care because there were so many citizens that were getting denied for insurance based on previous conditions because they would be so expensive. Young adults can stay on their parent’s insurance until they are 26, then have to apply for their own insurance. What is also great about this plan is that there is no lifetime spending cap. Under Obama Care you must have insurance so if your job does not give you insurance you must apply for Obama Care or buy your own private insurance. If not, you would have to pay a tax. When President Trump was put into office he removed this tax trying to save money on the spending of medicaid. Overall President Obama wanted to get more people insured
because when he took over the office there was a major problem with how many low-income families not having insurance.

Prior to Medicare in 1960, states would get paid by the federal government to have medical services for the general public. This insurance program would cover retirees, disabled workers, and their spouses. In 1972 the supplemental security income was created this was still fully funded by the government but changed the people who got benefits and gave more benefits to the mentally challenged and blind and disabled people. In the 1980s there were a plethora of changes. The changes to Medicaid expansion included many changes that allow low income pregnant women to get more benefits. In 1981 Omnibus Budget Reconciliation Act of 1981 required that states share hospital payments that pay for low income impoverished families. This program kept adding on benefits like this but was getting nowhere with the amount of people that were still uninsured. They kept on adding benefits to help more people be insured but were running out of money to help these people. Medicaid has been on the agenda since the 1960s when Lyndon B Johnson signed the Medicaid and Medicare programs and ever since then legislation has been changing who gets the benefits from this program.

The Affordable Care Act allowed states to expand Medicaid and the benefits they receive. Currently 37 states have decided to expand on Medicaid, one of them being the state of Indiana which implemented its HIP 2.0 plan. This is a program that Expands health insurance for low income Indiana residents, using money, under the Affordable Care Act that was promoted by Vice President Mike Pence. Customers pay into the system just like the Affordable Care Act which is usually very minimal. There are currently around 430,000 Indiana residents on this plan and could increase or decrease based on new laws that are being reviewed regarding the working requirements being suspended. Indiana residents between the ages of 19 and 64 whose family
incomes are less than approximately 138 percent of the federal poverty level and who aren’t eligible for Medicaid can be on this plan. (Status of State Medicaid Expansion, 2019)

Although the federal poverty level that people can receive Medicaid it is always fluctuating and getting changed by legislatures every year. Customers receive a power card with around 2,500 dollars. This is based on your family size and salary. The power card is used to pay medical bills and allows customers to pick and choose the doctors they want. The amount of money on this power card is based on your income, the number of dependents you have, if you are disabled, and if you are elderly. The money can be as low as 1,000 dollars per month or up to 6,500 dollars per month. This plan is put in place so that customers can learn how to spend their money better and learn how to save since they can choose their own doctors and the amount of medication they can receive. This plan is slightly more expensive than Obama Care but gives a lot of benefits that Obama Care does not have along with more money you can use for medical bills.

There are many issues with funding for Medicaid expansion and they are very controversial issues that have been trying to be fixed since 1965. One solution to these funding problems would be to have Medicaid for all so everyone is on the same plan. Everyone would pay into it and it would be funded by the general payroll tax. This is a plan that was proposed by presidential candidate Elizabeth Warren and is one of her main policies that she is trying to get implemented if elected as president. The other policy choice would be to lower the poverty rate from 139 percent of the poverty level to 130 percent and make more means testing so that the customers can get exactly what they need and not any extra so that the funding right now can support the plan. This is on the institutional agenda because it always has been on the agenda and isn't an issue just commonly out in the world like climate change. This is an issue that was
addressed by the government and has never stopped since it has started. Response to funding challenges for expanded Medicaid program under the Affordable Care Act would be a state-centric approach because it is a government issue and needs to be dealt with through legislation and high up government officials that have evidence to make these changes to Medicaid. Insurance companies will have a large number of lobbyists that would push against issues that would affect the amount of people that are going to be on private insurance.

Insurance lobbyists have overall been the second highest in the amount of money that they put into lobbying overall spending $2,704,636,807. In 2017 alone insurance companies spent 160 million dollars trying to influence the passage of the ACA and other developments under the Trump Administration. The only other industry that spends more than the insurance lobbyists is Pharmaceuticals and Health Products industry who have overall have spent 3,937,356,877 dollars (Frankenfield, 2018). The level of information on Medicaid is very high because it has been in effect since the 1960s and has had many changes, but it is such a controversial issue that a little change could mess the whole system up. The United States is one of the only countries in the entire world that has healthcare systems like Medicare and Medicaid. Other countries may have systems that are somewhat similar, although they are not as big as the United States or are a broken system in general. Obama Care was based off of a health care system in Australia, which is commonly known to have one of the best healthcare systems in the world. Australia's system is very similar to the United States health care as it is a single payer system. The single payer system is where the government offers one insurance plan, but most medical providers are still private. This would be very different from Health care for all plan that Elizabeth Warren is trying to implement. The casual understanding on Medicaid is very high
which Medicaid a routine understanding and information because most voters know these issues dealing with Medicaid and is always a big part of what people vote for.

The Affordable Care Act was a step in the right direction in terms of giving a universal basic healthcare coverage that is for everyone across America. However, more of an effort can be made to help lower costs even more and give more American citizens healthcare coverage that works for them and coverage that will ensure them a right to a healthy life for both them and their families. By lowering the rate for Medicare and Medicaid, more people will be able to access the good healthcare across America. More means testing for these programs will also be beneficial for those stuck in poverty since they will be more likely to be eligible for both Medicare and Medicaid. By tweaking both the mean tests and lowering the rate for Medicare and Medicaid, many Americans will be able to receive benefits they wouldn’t have before.

The healthcare system including Medicaid for all (hip 2.0) shows coverage for some Americans, just some. Medicaid for all is intriguing because of how controversial it is assumed to be. Since 1965, it sounded great when president Johnson announced that there should be some sort of healthcare for all citizens, especially affordable for such. Such of what is so important about a healthcare system is that it is controlled by government, by which means political conflicts and opinions on a local state level to a federal national level.

The Healthy Indiana Plan (HIP) has two paths of healthcare coverage. One being HIP Basic, and the other being HIP Plus. The initial plan selection for all members is HIP Plus which offers the best value for members. HIP Plus has comprehensive benefits including vision, dental and chiropractic. The member pays an affordable monthly POWER account
contribution based on income. There is no copayment required for receiving services with one exception: using the emergency room where there is no true emergency. In the state of Indiana, this is the most popular plan of healthcare. HIP Basic is the fallback option for members with household income less than or equal to 100% of the federal poverty level who don't make their POWER account contributions. The benefits are reduced. The essential health benefits are covered but not vision or dental services. The member is also required to make a copayment each time he or she receives a health care service, such as going to the doctor, filling a prescription or staying in the hospital. These payments may range from $4 to $8 per doctor visit or prescription filled and may be as high as $75 per hospital stay. HIP Basic can be much more expensive than HIP Plus.

But, Elizabeth Warren (senator from Massachusetts) is recommending a new health care program, which by far from top to bottom is a reconstructed plan. From her campaign website, Warren suggests that she would not raise taxes for the middle class, all in support for her 52-trillion-dollar healthcare plan. There are plenty of questions to ask when anyone brings a new policy choice up, but this plan is especially intriguing and different.

According to CNBC, the “Medicare for all” plan would appear to take her proposed wealth tax further under the health-care plan, saying wealth over $1 billion would be taxed at 6% rather than the currently proposed 3%. The change would raise an additional $1 trillion, the campaign said. Overall, Warren’s campaign estimates that it can take in $3 trillion for the health-care plan by “asking the top 1% of households in America to pay a little more. “Implementing this would not only be a struggle in congress, but as we now see Americans are not too welcoming of implementing a new healthcare plan, as seen with president Trump's administration recent try. Taxes on “the financial sector, large corporations and the top 1% of
individuals.” Changes in taxes on the investing community and large companies could raise an estimated $3.8 trillion, according to Warren’s campaign. Senator Warren’s plan would cut out the need to tax the middle class, all while still being able to fund the program.

As learned in class, healthcare is one of the most heated debates in our government, because it cost so much. Warren responded to criticism of Medicare for All from former Vice President Joe Biden, a top rival for the Democratic nomination. Biden, who supports a public health-care option, has argued Medicare for All would hurt labor unions that negotiated for their health plans. In response to Warren’s plan, Biden campaign spokeswoman Kate Bedingfield accused the Warren campaign of using “mathematical gymnastics” to hide that “it’s impossible to pay for Medicare for All without middle class tax increases.”

In fact, this would probably be the biggest implementation issue with Senator Warren's new plan. Criticism for how it will be funded, by not taxing the middle class and raising the taxes for the majority of Americans is troubling and problematic because then you have to look into other forms of resources that have not been touched before. So, when considering a replacement for HIP 2.0, revised or not, you have to consider how much money it will cost you in the end. There are many questions and results that could happen when you tax the top 1%, that being

Another implementation scenario when considering who will be covered under the plan is very complex. Similar to Obamacare, passing a health policy is one deal, but putting it into action is another. Data and analytics have become increasingly critical to the operation of any successful healthcare organization. And with the advent of healthcare imperatives such as value-based care and population health management, analytics technology has become more important than ever. The best practice is to bring all key stakeholders together to collaborate and debate on
which outcomes will be key to the success of the organization. Once these are decided upon, then a strategy for achieving outcomes can be put in place – then one can go and get the data, he added.

Elizabeth Warren truthfully believes that you in order to have a certain healthcare system that works, you must break it down starting from the bottom all the way to the top. Health care has emerged as perhaps the biggest flashpoint in the Democratic primary race so far. Presidential candidates have disagreed about whether to immediately move to cover all Americans through a single-payer system or move toward universal health care more gradually through methods such as a public option. Through a public option, you'd be able to choose your own insurance plan, and your own doctor. This is more likely considering the fact that the universal health care system is similar to what Canada has, whose rates are so much cheaper.

By looking at other policy issues surrounding HIP 2.0, such as the opioid crisis, medicine value, and body rights, you can see that this has actually been a policy that is much more underestimated to tackle. Tackling this issue means reaching out to all drug manufacturers, all the local police forces, and so many other options. Such a variety of obligations have to be met in order for Senator Warren to sign off on her bill. But in all reality, Indiana and its HIP healthcare plan can not even function right now because of a lawsuit, a much bigger problem. So, by implementing a policy that allows for a tax break, and cheaper consumer products makes sense, right? It should be that if you roll out a plan that makes economic sense, then it should get implemented by the United States government, on a national and federal level.

Under the new Trump Administration, some states now have work requirements for access to Medicare and Medicaid. Work requirement waivers require citizens applying for
Medicare and Medicaid to verify that they are employed, are searching for a job, or are in job training programs that help them get a job. They must also be doing this for at least 20 hours a week or 80 hours a month in the state of Indiana to get Medicaid and Medicare coverage. Work hour requirements can vary across states. Indiana is one of three states that still have work requirements for Medicare and Medicaid coverage as of 2019, but five more states have approved waivers that are not yet implemented, and seven states have waiver requests pending. Most Medicaid adults are already working and those who are not working are filing reasons why they cannot, including disability.

Those with better health and more education are more likely to be working. Most people on Medicaid right now are adults who work full-time but are working in low-wage jobs that have very little benefits. Most of the workers who are covered by Medicaid work in industries and jobs that also are very physically demanding such as food service industry or construction jobs. Those on Medicaid still for the most part have trouble with financial security and even struggle with food insecurity since they work in such low paying jobs full time and usually have families to feed.

Those that are under Medicare but can’t work face issues such as physical and mental disabilities, serious medical conditions, are attending school part time or full time, and have caretaking responsibilities. There is a correlation between those who don't have internet access, computers, or email and are not very savvy with computers and those under the umbrella of Medicaid. This is troubling since complying with policies to report their proof of work requires the internet and proving that you are exempt from working also requires the use of the computer and internet access. People who are eligible for coverage could lose coverage as a result of not being computer savvy and not having knowledge of how to report the requirements.
Most Medicaid adults are already working. Those who are not working or cannot work mostly report why they cannot work at all. Overall, 63 percent of adults with Medicaid are working either full or part-time. Those who cannot work usually file for disability as the main reason they cannot work and still end up receiving Medicare. Caregiving responsibilities or school attendance were other leading reasons reported for not working. Those who have very good health and with more education are more likely to be working. Health status is the strongest predictor of work. People who are in excellent health condition or in very good shape are 30 percent more likely to be working than those in just average or are in very bad health conditions. Education level is also a strong predictor of work. Medicaid eligibility levels are lower in the South, so more workers would be less likely to qualify for Medicaid compared to other regions of the United States. When looking at the age demographics it seems like those considered “middle aged” (26-45) and male are more likely to work than any other age groups and females.

The implementers of the work requirements would be the republicans in the house and also lobbyists for private insurance companies such as Blue Cross Blue Shield who were the leading insurance company in lobbying in 2018 that helped make these work requirements into law. The democrats would also be implementers as the republicans would need some votes of democrats, so they would work together to make sure that the requirements would not hurt the customers of the affordable care act and HIP 2.0. Overall these referendums got passed because the trump administration had a strong push to lower the amount of money that President Obama had for the budget of the Affordable Care Act. Hip 2.0 was pushed for by Vice President Mike Pence but with these new work requirements that would mean that President Trump's right-hand man would be going against this plan and causing over 80,000 people to lose their premiums for
insurance in general because they cannot meet these new work requirements. Trump's Administration believes that if you cannot work enough for these requirements then you are losing them money because customers need to work enough to cover the costs of customers medical bills. This would mostly affect the mentally disabled and elderly that cannot work these number of hours physically.

Some potential issues that have been previously touched on are that these work requirements could make some elderly or mentally disabled customers lose their premiums for insurance overall. Even though 40 hours a month seems reasonable for part time workers that have injuries that they are trying to work through or disabled people that have trouble with travel these 40 hours can be hard to get and could make them overwork and become a bad worker or take longer to recover from their injuries. This would also hurt children who are 18 that are working part time while going to college that would not be eligible for these requirements while working on school. There has already been a legal lawsuit that has been filed against this new reform that was put into effect by the Trump Administration early in 2018. The Indiana Family and Social Services Administration, FSSA, has temporarily suspended work requirements for people on the Healthy Indiana Plan, HIP. The move is in response to a federal lawsuit filed last year. The lawsuit is challenging HIP, Indiana’s Medicaid expansion plan, this threatens more than the requirement to report work or volunteer hours. The suit also challenges lockout penalties and premium payments included in the program.

The Affordable Care Act is an act that was put in place by President Obama but has had trouble finding ways to fund Medicaid expansions that allow for more people to be on this plan which 38 states have already done. One way to fix these funding challenges would be to add a Medicaid for all plan, which is what Senator Elizabeth Warren has proposed that would make it
so that there is a national Medicaid plan that every citizen is on so that there is no funding challenges because every citizen would pay into the plan based on general tax revenue, so that less fortunate families can also have insurance for medical visits. Another plan would be to add work requirements to the Affordable Care Act so that there are less people on the plan so that they can fund for the people that are working hard to receive their Medicaid. But there are issues with this plan as there has been huge backlash especially in Indiana as there have been lawsuits that have been filed that suspend the work requirements until the end of 2020. There have also been lawsuits and backlash from these work requirements in almost all 38 states that expanded Medicaid and got these work requirements from the Trump Administration. There needs to be changes for Medicaid expansion though, because there is not enough funding to cover all of the citizens that paid into the plan and are getting the return they wanted because funding is going down. Overall there Medicaid is a very controversial policy that has been changed nearly every presidency change with republicans wanting less people receiving free benefits and democrats wanting more people to be able to pay for medical bills.
Sources


