



Health Policy and Diabetes Care: Is It Time to Put Politics Aside?

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The burden of chronic diseases is enormous and growing, not only in the U.S. but also around the world. The control of chronic diseases requires effective approaches, including patient education, provider knowledge, and team care. Effective policies must also be enacted to address chronic diseases at a local, state, and federal level. This is especially true with regard to diabetes, which in the U.S. cost \$245 billion in 2012 and consumed 1 in every 10 health care dollars (1). The current trajectory for economic costs for the U.S. is not sustainable . . . perhaps the time is right to reevaluate our health policies.

Implementing policies to prevent or treat a disease is clearly not a trivial matter, and such efforts seem to be more effective when there are specific goals. Childhood immunizations provide a good example. In the 1990s, half of the children in this country were not appropriately immunized against communicable diseases (2). As was elegantly summarized (2), “It took strong evidence and a powerful political and organizational movement to get 90 percent of the children in this country immunized. That meant winning the support of the states, professional groups, pediatricians, and health maintenance organizations; obtaining funding from Congress so the shots could be provided in doctors’ offices, clinics, hospitals, and pharmacies at almost no charge; and

developing an immunization tracking system.”

What health policies might similarly alter the medical landscape for chronic diseases such as diabetes? In this regard, evaluating the impact of the Affordable Care Act (ACA) in general, and Medicaid expansion in particular, on diabetes identification and treatment would be of interest. In this issue of *Diabetes Care*, Kaufman et al. (3) provide one of the first reports on the effect of Medicaid expansion on diabetes diagnosis. The authors reported that in states that expanded Medicaid, more people were diagnosed with diabetes at an earlier stage of the disease.

Five years ago, the ACA was signed into law. It sought to improve access to care, provide new consumer protections, and improve the quality and lower the costs of health care in the U.S. A major provision of the ACA was to expand Medicaid, a jointly funded federal and state health insurance program for individuals with low income, to essentially all Americans below 138% of the federal poverty level (\$11,670 for one person and \$23,850 for a family of four in the continental U.S. in 2014) (4). People with moderate incomes (below 400% of the federal poverty level or \$46,680 for one person and \$95,400 for a family of four) (4) would in turn receive marketplace coverage through premium tax credits.

The expansion of Medicaid was designed to fill gaps in Medicaid eligibility. Historically, states administered Medicaid programs within broad federal guidelines and retained the authority to define eligibility, benefits, provider payment levels, and delivery systems (5). Income levels for eligibility were more stringent than that proposed under the ACA, and nonpregnant, working-age adults without dependent children or disabilities were categorically excluded from Medicaid coverage. Federal funding to states ranged from approximately 50% to 75% of the cost of Medicaid (5). With Medicaid expansion under the ACA, states would receive 100% federal funding for the first 3 years, which would be reduced to 90% by 2020. States that failed to expand Medicaid by January 2014, however, would lose federal funding.

In June 2012, the U.S. Supreme Court ruled that the threat to withhold a state’s Medicaid funding if the state declined to expand Medicaid was unconstitutional. Medicaid expansion thus became optional for states. By January 2014, 24 states had chosen not to expand their Medicaid programs. In those states, eligibility remained quite limited: the median income limit was just 50% of the federal poverty level (\$5,835 for one person and \$11,925 for a family of four) (6), and childless adults remained

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ineligible in nearly all states. In addition, because the ACA intended people with low income to receive coverage through Medicaid, it did not provide financial assistance for other coverage options to people below 138% of the federal poverty level but above the state's Medicaid eligibility level. Thus, many adults with low income fell into a "coverage gap."

At least 4 million American adults now fall into this coverage gap (7). More than half (54%) are between the ages of 35 and 64 years. Men account for 51% of people in the coverage gap. Approximately 44% are non-Hispanic white, 24% are Hispanic, and 26% are black. Approximately 86% live in the south. A quarter live in Texas, 17% live in Florida, 9% live in North Carolina, and 7% live in Georgia. Not surprisingly, adults without dependent children account for the majority (76%) of people in the coverage gap. Nearly half (47%) of people in the coverage gap report that their health is excellent or very good, but nearly one in five (18%) reports that he or she is in fair or poor health.

In this issue of *Diabetes Care*, Kaufman et al. (3) used the natural experiment provided by piecemeal expansion of Medicaid under the ACA to estimate the number of Medicaid patients 19–64 years of age newly identified with diabetes in states that expanded Medicaid and to compare that number to the number of Medicaid patients newly identified with diabetes in states that did not expand Medicaid. Patients were identified using a large national laboratory database with approximately 150 million patient encounters per year. Medicaid enrollees were identified on the basis of the payer listed on the test requisition, and state of residence was determined using the address provided for the patient at the time of testing. Patients were defined as not having diabetes if they did not have an ICD-9 diagnosis code indicating diabetes (250.X) or an HbA_{1c} level >6.4% during calendar year 2012 or calendar year 2013. In the pre-Medicaid (January–June 2013) and post-Medicaid (January–June 2014) expansion periods, Medicaid patients who did not have diabetes in the previous calendar year were identified as having diabetes on the basis of an ICD-9 diagnosis code for diabetes or an HbA_{1c} >6.4%.

Compared with the pre-Medicaid expansion period, the number of Medicaid recipients newly identified with diabetes

in the post-Medicaid expansion period increased by 13% (3). In Medicaid expansion states, there was a 23% increase in the number of Medicaid recipients newly identified with diabetes in the first 6 months of 2014 compared with the first 6 months of 2013. In states that did not expand Medicaid, there was an increase of <1% in the number of Medicaid recipients newly identified with diabetes in the first 6 months of 2014 compared with the first 6 months of 2013. In Medicaid expansion states, the numbers of newly identified Medicaid patients with diabetes increased in both age and sex categories. Mean HbA_{1c} among Medicaid recipients was also significantly lower in the expansion states (7.96%) than in nonexpansion states (8.14%) ($P < 0.0001$).

The researchers concluded that Medicaid expansion resulted in a substantial increase in the number of Medicaid recipients with newly identified diabetes (3). On the basis of their HbA_{1c} findings, they also surmised that Medicaid expansion resulted in the identification of patients with diabetes at an earlier stage of the disease. They further hypothesized that earlier diagnosis might lead to better long-term outcomes.

Although encouraging, none of these findings is particularly startling. If rates of screening and diagnosis remained constant, simply enrolling more medically underserved people in Medicaid and providing them with services would increase the number of people with newly identified diabetes. Similarly, it is not surprising that reducing financial barriers to care might encourage utilization, facilitate control, and improve outcomes.

Previous research has demonstrated that although adults with low income enrolled in Medicaid report more chronic health conditions and more mental health conditions than the uninsured, they are more likely to have their chronic health conditions diagnosed and controlled (8). In 2009, adult Medicaid beneficiaries <65 years of age with incomes at or below 138% of the poverty level were nearly twice as likely to have diabetes diagnosed as the uninsured (9% vs. 5%) (9). In part, the higher prevalence of diabetes among Medicaid enrollees may reflect Medicaid eligibility rules that extend coverage to people in poor health and with disabilities, and the lower prevalence of diabetes among the uninsured likely reflects a higher rate of undiagnosed

diabetes. Nevertheless, compared with uninsured low income adults with diabetes, those with Medicaid report more access to care, more use of services, and lower out-of-pocket expenditures for medical care (10).

The 2008 Oregon Medicaid expansion, which provided coverage for adults with low income based on lottery drawings from a waiting list, afforded an early opportunity to more rigorously evaluate the effects of Medicaid expansion (11). Data from more than 6,000 adults randomly selected to be able to apply for Medicaid coverage and nearly 6,000 adults who were not selected demonstrated that Medicaid coverage significantly increased the likelihood of being diagnosed with diabetes and increased the use of diabetes medications and preventive services. Another study of three states that substantially expanded Medicaid in 2001 and 2002 (Arizona, Maine, and New York) and three neighboring states that did not expand Medicaid (Nevada, New Hampshire, and Pennsylvania) demonstrated that 5 years after Medicaid expansion there were significant reductions in adjusted all-cause mortality, especially among adults 35–64 years of age, non-whites, and residents of poorer counties (12).

Kaufman et al. (3) have again demonstrated that Medicaid expansion increases the number of low-income Americans with newly identified diabetes and will likely improve their outcomes. The data demonstrate the benefits of Medicaid expansion, yet nearly half of our states have chosen not to expand this benefit to their citizens. The real-world benefits and costs of Medicaid expansion merit additional research and civil debate. And perhaps most important, their results should be used to guide health policy to address the growing burden of chronic diseases.

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