The Limits of Medicaid Reform in Pennsylvania

Thinking Regionally about Access to Insurance and Health Care under the Affordable Care Act

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States' varied decisions with respect to Medicaid expansion under the Affordable Care Act have drawn significant attention to questions about equity across states. Missing from the conversation is consideration of the varied impact that reform will have within states. This article considers how low-income Pennsylvanians will fare under Medicaid expansion. Although Medicaid reform has already expanded access to insurance to significant numbers of low-income residents in the state, improvements in access to health care are mediated by pre-existing regional inequalities in social determinants of health and by Pennsylvania's system of health governance. Drawing on lessons gleaned from the literature on regionalism, and examples of success in states that have adopted regional approaches to health delivery, we offer a theoretical approach for thinking regionally in Pennsylvania by building opportunities and capacities for cross-jurisdictional approaches to health and health care access.

The Patient Protection and Affordable Care Act (Public Law 111–148 [123 Stat. 119 (2010)] [ACA]), is designed to make the health care system more effective and efficient, while expanding insurance coverage and preventative care to millions of Americans. The ACA alters the existing health care system by expanding the regulatory role of the federal and state

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governments and by requiring insurers and health care providers to restructure their personnel and services to accommodate the requirements of the law. Not only is "Obamacare" the most significant health care overhaul since 1965, when Medicaid and Medicare were instituted, but the ACA also provides a unique window for examining the politics of implementation of federal policy reform across a diverse and fragmented nation.

Extending Medicaid to uninsured low-income citizens is a key mechanism of the ACA. As originally conceived, starting in 2014, an expanded Medicaid extends coverage to all individuals under 65 years of age with incomes up to 138% of the federal poverty level (Kenney et al. 2012).[1] The federal government is picking up 100% of the costs of new enrollees initially, reducing its contributions to these costs to 95% in 2016, and to 90% in 2020. The original ACA required states to expand Medicaid under threat of loss of all federal Medicaid reimbursements for existing enrollees.[2] In *National Federation of Independent Business et al.* v *Sebelius, Secretary of Health and Human Services, et al.* (2012), however, the Supreme Court held that, because Congress's tax and spend powers do not extend to compel the states to enact or administer federal regulatory programs, the mandated Medicaid expansion was unconstitutional. The Court's decision, in short, made Medicaid expansion, and therefore also full implementation of the ACA, a matter of state choice.

States' varied decisions with respect to Medicaid expansion have drawn significant attention to questions about equity *across* states (for example, Jacobs and Callaghan 2013). To be sure, since Medicaid's inception in 1965, states have been required to comply with federal criteria—determining, for example, who receives care and what funds are provided at what costs—as a condition of receiving federal Medicaid funds. However, eligibility requirements, scope and breadth of services and benefits, and share of Medicaid funding provided by the federal government vary widely across states. As of June 2015, 30 states (including DC) have opted into adopting the ACA Medicaid expansion, 19 have opted out, and 2 remain undetermined (Kaiser Commission 2012). Medicaid reform is a divisive issue; all of the states opting out are Republican-led (although 10 states had Republican governors when they decided to expand) and no states in the Deep South are expanding, making Medicaid reform regionally concentrated.

Missing from the national conversation about ACA outcomes is consideration of the varied impact that reform will have *within* states. States have diverse systems of health governance that are not inconsequential to health outcomes. This is especially true for low-income residents who face the greatest obstacles not simply to obtaining health insurance, but to accessing preventive

care, clinical care, and other health services. In this context, Pennsylvania is uniquely situated for two reasons. First, it is one of only a handful of states that has a mixed, or hybrid, health governance structure the consequences of which remain uncertain alongside ACA reforms.[3] Second, Pennsylvania's eligibility requirements for Medicaid prior to Obamacare were among the most restrictive in the nation, positioning the state to exponentially expand Medicaid enrollees and thereby significantly alter the landscape of health within its borders. The state of Pennsylvania has a vested interest in improving health for Medicaid enrollees, as they accounted for close to a quarter of the state's population prior to Obamacare. Politically speaking, Pennsylvania is also somewhat unusual, having first opted out of the federal expansion in favor of a state-run demonstration project, only to quickly reverse course a few months later following a change in control of the governor's office.

How will low-income Pennsylvanians fare under ACA Medicaid reform? It is certain that hundreds of thousands of previously uninsured residents will gain health insurance, but consequences for health care and health outcomes among the population are less clear. In this article, we take stock of Medicaid reform in Pennsylvania with three goals in mind. First, after a brief historical review of the political context behind the state's labored decision to expand Medicaid, we provide a sketch of reform outcomes to date, focusing on low-income residents' access to health insurance. Health insurance is a precursor to, not the equivalent of health. Therefore, our second goal is to explicate barriers to health among low-income Pennsylvanians—barriers that include geographical variation in access points to primary health care. *Where* low-income residents can access health is determined in part by social and economic conditions of unemployment, poverty, transportation, and housing. It is also determined by the structure of health governance within the state and it is this latter variable that holds our primary interest. Not only does the ACA largely sidestep these interdependent determinants of health inequality, but by centralizing the administration of health, the governance structure of Pennsylvania state health may exacerbate health inequalities. Thus, our third goal is to suggest a theoretical framework for approaching health regionally in Pennsylvania, one that is open to reforming administrative structures of health governance to focus on regional, cross-jurisdictional approaches to public health and health care access. Absent more comprehensive reform of the state's public health system that considers regional variation in the conditions that facilitate health, Medicaid reform will provide access to health insurance but, by itself, not necessarily better health outcomes for low-income Pennsylvanians.

Political Prelude

One of the 26 states party to *National Federation of Independent Businesses v Sebelius*, Pennsylvania initially declined to participate in the federal Medicaid expansion. Following a delayed response to the Court decision, Pennsylvania Republican governor Tom Corbett led his administration in developing a state-run alternative to the federal expansion to pay private insurers to cover the uninsured using newly available Medicaid funds.[4] After negotiating for over a year with the Obama administration, the Centers for Medicare and Medicaid Services (CMS) granted Pennsylvania a federal waiver in August 2014, enabling the Corbett administration to modify the state's existing Medicaid program to expand access to health insurance to adults with incomes up to 133% of the federal poverty level. Corbett's plan, Healthy Pennsylvania, could enroll up to 600,000 new citizens for health care coverage beginning January 1, 2015. Healthy Pennsylvania had two core components. First, it modified the state's existing Medicaid program through changed benefit plans, implementation of cost-sharing premiums, and establishment of incentives to encourage healthy behaviors. Second, adults previously ineligible for Medicaid but newly eligible under the ACA's expanded requirements could gain access to health insurance through private managed health plans, or Private Care Option service delivery systems.[5]

Among the most controversial of these changes were cost-sharing stipulations and eligibility requirements linking health insurance access to "employment related activities." The demonstration project approved by CMS permitted the state to charge monthly premiums for individuals with incomes up to 100% FPL during year two not to exceed 2% of household income (during the first year of the demonstration, no premiums were charged). Individuals with incomes below 100% FPL could also be charged copayments in some circumstances. After year one of the demonstration project, individuals could reduce their cost sharing responsibilities by demonstrating healthy behaviors—including, for example, annual wellness exams and an established record of timely copayments.[6] In its original formulation, Healthy Pennsylvania linked health insurance eligibility for able-bodied adults, ages 21–64, working fewer than 20 hours per week to proof of engagement in "employment related activities," such as job training. Political contingencies eventually forced Corbett to weaken these conditions, such that the CMS waiver stipulated that "health coverage provided by the Medicaid program and this demonstration will not be affected by" the state's efforts to encourage employment through incentives to join training and work related activities.[7]

Early in his administration, Corbett criticized the ACA as "federal overreach" and referred to Medicaid as a "broken system," arguing "it would

be financially unsustainable for the taxpayers," to participate in the federal expansion (Beeler 2013). At the same time, however, like many governors, Corbett faced political and budgetary pressures alongside large populations of low-income residents lacking health insurance. Indeed, the Corbett Administration previously eliminated adultBasic, which had provided health insurance for low-income working adults ineligible for Medicaid, generating even greater need for affordable accessible health insurance.

Corbett's "private option" allowed the state to capitalize on additional federal funding without compromising conservative principles. One journalist referred to this approach, shared by Arkansas, Iowa, and Michigan, as "making Medicaid more Republican" (Ramsay 2015). Corbett claimed a political victory in securing "a plan that was created in Pennsylvania for Pennsylvania—a plan that would allow us to reform a financially unsustainable Medicaid program and increase access to health care for eligible individuals through the private market," (in Wenner 2014) but the political realities were more complicated. The CMS demonstration waiver imposed considerable restrictions on Healthy Pennsylvania, and ultimately, the state nudged its way toward expanding Medicaid with the help of federal funds.

Corbett's Healthy Pennsylvania was criticized both within and outside of the state and its brief life was both cause and consequence of the electoral politics of the 2014 gubernatorial elections. The second half of Corbett's first term saw declining public approval ratings (University of Virginia's Larry Sabato characterized Corbett "the incumbent Republican governor most likely to lose in 2014" [in LaRosa 2013]). Corbett's Administration was flanked by seemingly endless bad news: drastic education cuts, teacher layoffs, controversial abortion legislation, poor job growth. His administration was also troubled by fallout from his own verbal gaffes and relative weak likeability compared to the Democratic challenger, Tom Wolf. One of the most watched gubernatorial elections of 2014, the Corbett campaign was heavily funded by the Republican Governors' Association; Wolf, CEO of a family-owned building materials business and former state revenue secretary, donated $10 million to his own campaign and received support of major labor and teachers' unions in the state. Campaigning with a promise to revoke Healthy Pennsylvania in favor of expanding the state's preexisting Medicaid program with support from ACA federal funds, Wolf secured victory with 55% of the vote. In what was characterized as an otherwise Republican friendly midterm election, Corbett became the first incumbent governor in Pennsylvania not elected to a second term (Olson and Esack 2014).

Despite his loss in November 2014, Corbett's administration began implementation of Healthy Pennsylvania in January 2015. At the time of Wolf's

data include primary care physicians specializing in medicine, family medicine, internal medicine, or pediatrics and provide a measure of the availability of health care and access to providers. As shown, many counties with higher ratios of population to primary care physicians (those shaded darker on Figure 3), also have few if any FQHC/RHCs, potentially forcing residents to forgo preventive care, or to seek out hospital emergency rooms for nonemergent care. Comparing Figures 2 and 3 further emphasizes the need to consider more access to preventative health care for low-income residents. For example, counties such as Pike, Perry, Monroe, and Bedford, which lack a sufficient number of physicians to serve the overall county population, *also lack* federally assisted health centers for low-income residents *and* have seen higher increases in Medicaid enrollment. Clearly, there is a need to consider a better way to organize health services for low-income individuals living in these regions.

While these figures suggest that the state's hybrid system of health governance promotes horizontal equity in some respects—nearly every county has a state-run health center, for example—it is clear that there is considerable variation in the extent of need among low-income residents across counties and in structural and environmental factors across the state. In short, low-income Pennsylvanians faced varied access to primary health care. As suggested above, the increase in insured adults as a result of Medicaid expansion could lead to *greater* health inequality, as those lacking access to health services, due to a limited number of physicians or facilities, maintain their current level of health while those living in areas with more options for health care have greater access. Additionally, previously insured individuals may face difficulties scheduling health care visits due to the increase in demand and limited supply of health care workers.

The remainder of our article suggests a theoretical way of thinking regionally to derive the greatest benefit from the ACA's twin promise of improving health *insurance* and health *care* for low-income Americans.

Seeking Regional Solutions to Health Challenges in Pennsylvania

The ultimate success of the ACA will depend in large part on the willingness and ability of states, health insurers, and health care providers to transform the existing health care system. Because federally designed Medicaid reform relies on states to run and implement the expansion, it is inherently linked to a preexisting landscape of health inequalities, socioeconomic disparities, inequalities in the social determinants of health, and varied obstacles to care.

In this context, location matters, as health is shaped by many factors that lie outside the boundaries of health care, including access to employment opportunities, adequate transportation, environmental issues such as air and water quality, and racial equity. Literature in the field of regionalism, for example, suggests that neighborhood access to healthy food, concentrations of poverty within geographic regions, and resource disparities within larger regional contexts are all factors that affect health outcomes at both individual and community levels (e.g., Hutson et al. 2012; Lynch et al. 1998). Moreover, individuals rely on their local communities for health care; therefore, measurement of the ACA's success must include consideration of the equity, accessibility, and affordability of services within more localized areas.

A regional boundary is defined by where people reside, travel, work, shop, and play (Hamilton 2014; Miller 2002). The recognition that municipalities within a region are interdependent is now commonplace within research and practitioner communities (Dreier et al. 2004; Hamilton 2014; Ledebur and Barnes, 1993; Orefield 2002; Pastor et al., 2000; Rusk 2003; Savitch et al. 1993; Savitch and Vogel 2000; Swanstrom et al. 2002). While there is debate about the extent and direction of this interdependency, a regional perspective is critical for understanding social disparities and economic growth at the local government level. Regions present unique governing challenges because they typically include multiple local governments and often lack static legal boundaries.

The subject of health equity itself is well traversed—scholars and practitioners have long drawn attention to issues related to population health: racial and ethnic disparities in health and health care, state and local policy efforts to alleviate health disparities; the interconnectedness of residential segregation, lack of access to health care, environmental stressors (such as violence), and community infrastructure (e.g., Institute of Medicine 2011; Kirby and Kaneda 2005; Lynch et al. 1998; Schulz et al. 2002). These findings are increasingly considered in the context of regionalism; indeed a recent Policy Link report suggests, "much of the innovative work around health and regional equity is occurring at the intersection between health and other areas such as transportation, housing, and economic opportunity" (2002, 23). Past research has linked race-based residential segregation and socioeconomic status to the social and material resources that promote health and limit disease (Schulz et al. 2002).

Most critically for our purposes, studies of healthcare utilization suggest that an individual's decision to access primary health care services depends upon spatial considerations, including regional availability and regional accessibility and aspatial factors such as income, race, ethnicity, education level, or sex (Wang and Luo 2005). Of particular importance, researchers estimate that

individuals are more likely to access services within a 15-mile radius or not exceeding a 30-minute barrier (e.g., Luo 2004; Wang and Minor 2002).

While Medicaid expansion has already significantly expanded access to health insurance for more than 400,000 low-income Pennsylvanians, far surpassing the numbers of individuals who have enrolled in individual insurance plans through the federal marketplace, our concern is the next step, how to ensure access to preventive and primary care for low-income individuals with or without health insurance. Translating gains in health insurance into healthier residents and greater health equity across the state will require coordinated regional strategies. These strategies include changing state health governance structures to establish a more decentralized public health system, one that allows for regionalized implementation and state support for new collaborative regional health care systems.

For example, recent research suggests that centralized, state-run health governance systems—such as the system characterizing health governance in Pennsylvania—are associated with the lowest health outcome measures on several dimensions of health, including adult smoking, low birth weight, teen births, and preventative screenings for breast cancer and diabetes (Hays et al. 2014). One of the benefits of the U.S. system of federalism is the ability to learn from state-level variation in public health delivery systems. Here, we briefly draw on Minnesota and Massachusetts, two states consistently ranked among the healthiest in the nation by the United Healthcare Foundation and Association of State and Territorial Health Officials. Like Pennsylvania, both states have histories rooted in strong local governance. Unlike Pennsylvania, both Minnesota and Massachusetts have integrated regional approaches to public health through statewide planning that emphasizes devolving accountability and health delivery planning to local governments with state-level oversight and support.

Regional Public Health in Minnesota

In Minnesota, the Community Health Services system has been in place since 1976, when the state passed the Community Health Services Act (Minn. Stat. § 145A), now called the Local Public Health Act. Unlike Pennsylvania's Act 315, which permits, but does not require, counties and municipalities to create health departments, the state of Minnesota designates Community Health Boards (CHBs) as the legal governing authorities for local public health. CHBs can be multi-county, single-county, or city-based but must serve a minimum population equal to 30,000 people (Minnesota Department of Health 2016). CHBs are better positioned to tailor health services to fit the needs of

a smaller population than is possible with a state-governed structure. Funding for CHBs is provided through a mix of federal, state, and local funding as well as fees and reimbursements. Non-categorical state funding provides the base funding for the CHBs in addition to targeted funding to address state-level public and community health priorities (Mays and Frauendienst 2014). A recent report measuring performance indicators on CHBs suggests that many work with local partners to increase health education programming, particularly in school settings. Also, most engage in activities to promote healthy behaviors, particularly nutrition and physical activity (Minnesota Department of Health 2014). Other program areas include maternal and child health, infectious disease prevention, and promotion of environmental health, such as radon testing.

One of the challenges faced by Minnesota CHBs is funding. Even though the state provides significant governmental transfers, many CHBs struggle to provide sufficient local tax and non-tax revenue (Minnesota Department of Health 2015). Changes in population demographics, including the decline of rural populations, are another concern. In spite of these challenges, evidence suggests that there is increasing ability for CHBs to meet state performance standards and the state is encouraging all CHBs to apply for Public Health Department Accreditation, which would provide additional technical support and research to improve service delivery. Minnesota's CHBs provide decentralized health centers with strong support from the state, providing residents more targeted services and programming to meet the unique needs of each region.

Regional Public Health in Massachusetts

If states such as Minnesota provide empirical support that legislative and administrative decentralization may help improve community health, Massachusetts provides an example of the benefits of engaging public and private services providers in regionalizing public health. Massachusetts is both one of the healthiest states in the nation and characterized by one of the most decentralized systems of health. Historically, each municipality was responsible for providing public health services and acted as the primary funder for these services. In fact, until 2006, state law did not provide for the opportunity for any direct funding for public health. With over 300 communities and varying degrees of financial capacity, state leaders recognized that the existing system was no longer sustainable and that a more centralized approach, with greater state-level engagement, was needed to ensure equitable access to care for all citizens.

Following on the heels of the landmark Massachusetts health reform that was the precursor to the ACA, local health department and state officials prepared a report recommending several improvements to the public health system (Hyde and Tovar 2006). These recommendations, along with further study of the problems by public health leaders, led to the creation of several additional policy changes. First, in December 2006 the state launched the Massachusetts Public Health Regionalization Project with the goal of establishing consortiums of local health departments across multi-jurisdictional boundaries to provide a "consistent standard of care and equal level of services." (Massachusetts Public Health Regionalization Project 2016). Six regional consortiums received Public Health District Incentive Grants from the state, supported by a grant from the U.S. Center for Disease Control. These consortiums bring together local health boards and community health care provides to create regional health improvement plans and coordinate services. For example, the Central Massachusetts Regional Health Alliance, comprising seven local health boards and over 90 community organizations and hospitals, developed a strategic plan that includes a focus on health equity and health disparities (Central Massachusetts Regional Public Health Alliance 2014). Second, to further enable and encourage regionalization, in 2008 state policy makers revised Chapter 529, an Act Relative to Public Health Reorganization, which removed barriers to regionalization. This law provides the legal basis for state funding for public health but retains legislative prerogative for development of the funding formula and subsequent annual funding. Third, in 2013, Massachusetts created the Office of Local and Regional Health, the hub for partnerships between the state Department of Health and Human Services and regional consortiums.

This office is similar in scope to Pennsylvania's Bureau of Community Health Systems. The evolution of the expansion of state efforts to support the new regional collaborative and local health boards is still relatively new. However, research by the Institute of Community Health points to early positive outcomes in the District Incentive Grant Program and regional health consortium (Hays et al. 2014).

Opportunities for Regionalizing Public Health in Pennsylvania

Our goal here is not to suggest a one size fits all approach. To be sure, Massachusetts and Minnesota are significantly different both from each other and from Pennsylvania culturally, politically, geographically, and economically. Rather, our goal is to draw attention to the experiences in Minnesota

and Massachusetts, and to emergent research on public health governance, to suggest that thinking regionally offers innovative routes for improving health care and population health outcomes. Pennsylvania is well positioned to encourage greater decentralization of public health by revising existing legislation to encourage a regionally driven public health system. For example, policymakers could consider revising Act 315 to provide greater incentives for counties and municipalities to create local health departments and multijurisdictional health departments that include two or more counties as a regional economic entity.

Regional health departments are beneficial for several reasons. First, by design, they would be attuned and responsive to residents within identified geographies, including at-risk populations in cities and suburbs. Currently operating Health Bureaus offer more expanded clinical services, environmental health, and targeted community education opportunities to residents than do state-run health centers and are more adaptable to local community issues. Regional health departments, we expect, would provide the same attention to community needs. Second, regional health departments would increase community engagement in public health. Act 315 requires that county commissioners appoint five residents within a health department's geographic boundary to serve on a Board of Health, ensuring greater localized autonomy over public health provisions than is current practice in most counties in the state. The third benefit is that localized health departments would provide opportunities for greater coordination of regional health services including, for example, county departments of Human Services in the areas of mental health, aging, and children and youth services. Regional health departments would also have greater ability to coordinate services directly with nonprofit and private providers to improve regional health as shown through the examples of CHBs and Regional Health Departments in Massachusetts.

If regionalizing Pennsylvania's approach to health is a good idea, and we think it is, there are important funding, cost, and political considerations (we say more on this below). A large question, in light of current state budget woes, is funding. Deeper consideration of the cost of implementation is necessary; however one assumption is that expenditures for state health centers would be shifted from the current state health centers, which would no longer be needed, to the new regional entities. Further funding would be raised through local sources, federal grants, and service provision.

An even more politically feasible and practical step toward thinking regionally is to encourage growth and proliferation of FQHC/RHCs and similar organizations providing community-level primary care. FQHC/RHCs receive funding from the Health Resources and Services Administration of

the U.S. Department of Health and Human Services. Maximizing the potential for federal funding by providing additional state funds to organizations operating within high-need locations would serve those most in need of affordable health services.

Combined, these efforts would provide a better foundation for reducing health disparities by recognizing the importance of regional health planning that includes collaboration with neighboring government entities as well as nonprofit and private-sector providers.

Regional Case Study of the Lehigh Valley

Figure 4 provides an example for thinking regionally in the way that we imagine by examining the spatial relationships of public health offices and FQHCs in the Lehigh Valley region of Pennsylvania. The Lehigh Valley region comprises Lehigh and Northampton Counties, 62 municipalities, and 17 school districts. The Valley is home to approximately 600,000 residents, with median income ranging from $54,923 to $60,097. Approximately 14% of Lehigh

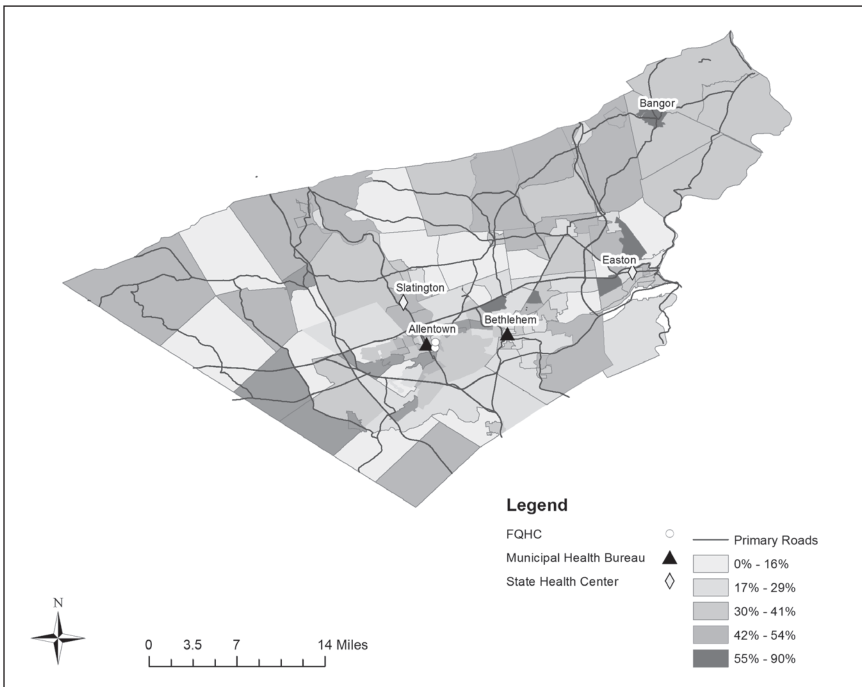

Figure 4. Percentage Uninsured up to 138 FPL by Census Tract, Lehigh and Northampton Counties. *(U.S. Census Bureau, American Community Survey, 2008–2013; Pennsylvania Department of Health; and Pennsylvania Association of Community Health Centers.).*

County lives at 100 FPL; in Northampton, the poverty rate is just under 10%. Lehigh County is home to Allentown, the third largest city in the Commonwealth, with a poverty rate of 28%. As shown in Figure 4, the state operates a health center in each county, while the cities of Allentown and Bethlehem have their own Health Bureaus. There is also an FQHC located in Allentown.

Given Allentown's relatively high poverty rate, it is an obvious place to locate services designed to provide affordable health care. Nonetheless, closer examination of census tracts in the Lehigh Valley as a whole suggests there are other places in the region that would benefit from more accessible health care. Following Governor Wolf's expansion of traditional Medicaid, we would expect most areas on Figure 4 to show fewer uninsured over time, as more individuals register for HealthChoices in the coming years. Indeed, recall our discussion above and Appendix A, which shows that Lehigh and Northampton exceed the statewide average rate of change in Medicaid enrollments in the year stretching from June 2014 to June 2015. Lehigh's Medicaid enrollment increased by about 22%; in Northampton, the increase was almost 24%.

We expect that some of these individuals will now seek more frequent primary and preventative care. However, like many regions in the state, the Lehigh Valley is characterized by barriers to health care and improved health outcomes that cannot be overcome simply through the extension of health insurance. Community health needs assessments in the region conducted in compliance with the requirements of the Affordable Care Act have demonstrated, for example, that transportation, housing, employment, and cultural and language barriers are important factors explaining disparities in health outcomes and access to preventive health services (Mathews 2012; Mathews-Schultz and Brill 2015). Further, the needs of residents living in the urban core areas of the Lehigh Valley differ from those living in the suburban and rural outskirts of the region; access (particularly for residents lacking transportation) is particularly significant in the rural areas. Communities in the northern and southern tiers of the Lehigh Valley, for example, lack access to the region's bus system, the only form of public transportation.

Interestingly, policy and county leaders in the Lehigh Valley previously took steps toward creating a bicounty health department in the region. Lessons from this experience reveal both the appeal of thinking regionally about health and the practical and political barriers to implementing regionalism without clear incentives and support from state (and possible) federal institutions. In 2010, several organizations within the health care community in Lehigh and Northampton Counties, including the two municipal health bureaus, Two Rivers Health Foundation, and the local hospitals, proposed the creation of a new bureau that would replace the existing Allentown and

Bethlehem Health Bureaus. That proposal was for a larger multicounty entity that would offer expanded services and new locations in Easton, Bangor, and Slatington, three areas with a large number of low-income residents that tend to be underserved by the existing urban core health bureaus.

Unfortunately, despite empirical evidence that a bicounty health department would better serve the health needs of the region's low-income population, these efforts failed to gain enough political support among either Lehigh or Northampton County political elites and elected leaders who had to approve its creation. The main sticking point for the county commissioners and opponents of the regional health department stemmed from the proposed expectation that each county and the three cities would contribute resources to operate the new bureau. In the midst of the recession, and with Tea Party Republicans on both the Lehigh and Northampton county councils opposed to increasing the size of government, this requirement was not politically viable. It is likely that opposition to regional health bureaus will continue without state-level reforms to decentralize public health similar to those in Minnesota and Massachusetts and incentives to make it easier for regions to expand autonomy and accountability.

Moving Forward after Obamacare: Tentative Conclusions and New Questions

It is certain that large numbers of low-income previously uninsured Pennsylvanians will gain health insurance as a result of the state's Medicaid expansion. Early indications suggest that, in the first half of 2015, a far greater number of residents enrolled in HealthChoices—the newly designed and named state-run Medicaid program—than enrolled in the private health marketplace created under Obamacare. It is difficult to overstate the significance of Medicaid in extending health insurance to low-income residents in the state. More than 400,000 Pennsylvania residents are newly insured as a result of the Medicaid expansion.

With this backdrop, our primary goal in this article was to suggest that the pre-existing landscape of health inequalities in access to care across different regions of the state, coupled with the centralized hybrid structure of health governance, will mediate and potentially limit health outcomes among the newly insured population. Better and more health insurance will not necessarily lead to better health care or improved health outcomes. Access to preventive health services and primary care physicians is not distributed equitably across the state; those newly insured and those who remain uninsured

will have differential access to health care depending to large degree on where they live.

Emergent literature on regionalism and public health, coupled with experiences of innovative regional approaches in states such as Minnesota and Massachusetts, suggest that there are tangible ways Pennsylvania (and other states) can think regionally about how to best address inequalities in access to health. Many academics, research institutions (see, for example, the Institute for Public Policy and Economic Development), and practitioners advocate statewide regionalization for many policy areas beyond health. For example, these areas include police, fire, public education, water and wastewater, economic development, transportation, and planning.

Statewide obstacles similar to those found in the Lehigh Valley have frustrated these efforts to regionalize while, ironically, the fragmentation of Pennsylvania's local governments further contributes to service delivery challenges and fiscal stress. Nonetheless, there has been limited success in regionalization that gives us reason for optimism. Since 1971, for instance, 29 regional Intermediate Units (IUs), multijurisdictional entities, have provided educational services and instruction. IUs operate as a statewide network to provide services to school districts and other educational entities that would not be provided if each district were expected to provide its own services; while IUs cannot raise their own tax revenues, they do charge fees for service and receive state and local funding (Joint State Government Commission 1997). There are other examples of successful regionalization in the state; there are at least 35 regional police departments across 125 municipalities, and interstate and intrastate regional planning commissions are now commonplace throughout the Northeast.

As we have shown throughout this article, Pennsylvania's health system requires an overhaul. Pennsylvania continues to rank below national averages on measures of state population health. The Kaiser Commission recently reported that individuals living in rural areas of the state are most likely to face the greatest obstacles in accessing health care and in obtaining improved health outcomes. A State Health Care Innovation Plan awarded to Pennsylvania in 2013 has begun the development of telemedicine initiatives to help address some of these disparities (Kaiser Commission on Medicaid and the Uninsured 2016). While a worthy goal, the above suggests that without a more regionalized strategic focus on services and service access barriers, many low-income Pennsylvanians will continue to lack access to health care and improved health, even if newly insured as a result of the ACA Medicaid expansion.

APPENDIX A

Table A.1. Population, Uninsured, and Medicaid Enrollees Pre- and Post-Medicaid Expansion

	Total Population (2013)	Population 18–64 under 138 FPL (2013)	Number 18–64 Years Old under 138 FPL Uninsured (2013)	Percentage Population 18–64 under 138 FPL Uninsured	June 2014 Adult Medicaid Enrollees	June 2015 Adult Medicaid Enrollees	Percentage Change in Adult Medicaid Enrollees June 2014–June 2015
STATE TOTAL	**12,311,644**	**1,380,082**	**399,086**	**28.92%**	**1,126,396**	**1,383,675**	**18.6%**
Adams	96,925	7,496	2,920	38.95%	5,001	6,721	25.6%
Allegheny	1,193,285	132,085	33,783	25.58%	102,176	122,496	16.6%
Armstrong	67,794	7,627	2,240	29.37%	7,242	8,579	15.6%
Beaver	167,234	16,257	3,741	23.01%	15,734	18,898	16.7%
Bedford	48,646	5,355	1,656	30.92%	4,823	6,074	20.6%
Berks	398,894	43,674	14,482	33.16%	34,594	42,222	18.1%
Blair	123,607	15,274	3,659	23.96%	14,343	17,313	17.2%
Bradford	61,555	7,268	2,246	30.90%	5,745	6,769	15.1%
Bucks	617,161	30,366	9,234	30.41%	28,206	35,992	21.6%
Butler	179,401	15,311	4,310	28.15%	10,862	13,324	18.5%
Cambria	134,495	16,018	4,579	28.59%	15,125	18,095	16.4%
Cameron	4,923	494	118	23.89%	640	738	13.3%
Carbon	64,074	6,876	1,976	28.74%	4,960	6,312	21.4%
Centre	137,110	28,254	3,904	13.82%	6,347	7,987	20.5%

Chester	490,199	29,662	10,150	34.22%	16,945	22,415	24.4%
Clarion	37,855	5,953	1,341	22.53%	3,867	4,520	14.4%
Clearfield	76,463	9,953	3,050	30.64%	9,666	11,448	15.6%
Clinton	36,769	5,218	989	18.95%	3,953	4,610	14.3%
Columbia	62,763	9,685	2,090	21.58%	5,413	6,565	17.5%
Crawford	84,327	11,526	3,565	30.93%	9,117	10,684	14.7%
Cumberland	223,262	16,941	4,751	28.04%	10,984	14,349	23.5%
Dauphin	262,878	28,370	8,560	30.17%	22,093	29,648	25.5%
Delaware	538,128	45,180	13,421	29.71%	42,216	49,127	14.1%
Elk	31,411	2,528	517	20.45%	2,728	3,133	12.9%
Erie	268,044	37,003	9,161	24.76%	31,387	38,469	18.4%
Fayette	132,138	20,286	6,101	30.07%	20,199	23,785	15.1%
Forest	4,803	690	225	32.61%	574	715	19.7%
Franklin	147,640	13,354	5,320	39.84%	9,333	12,396	24.7%
Fulton	14,641	1,519	458	30.15%	1,347	1,634	17.6%
Greene	34,089	4,472	1,195	26.72%	4,429	5,122	13.5%
Huntingdon	40,688	4,579	1,196	26.12%	4,322	5,131	15.8%
Indiana	83,219	13,903	3,496	25.15%	7,415	9,433	21.4%
Jefferson	44,174	5,535	1,585	28.64%	5,128	5,984	14.3%
Juniata	24,359	2,659	910	34.22%	1,828	2,165	15.6%

Table A.1 (*continued*)

	Total Population (2013)	Population 18–64 under 138 FPL (2013)	Number 18–64 Years Old under 138 FPL Uninsured (2013)	Percentage Population 18–64 under 138 FPL Uninsured	June 2014 Adult Medicaid Enrollees	June 2015 Adult Medicaid Enrollees	Percentage Change in Adult Medicaid Enrollees June 2014–June 2015
Lackawanna	206,318	23,230	6,459	27.80%	21,450	26,532	19.2%
Lancaster	508,397	45,935	14,756	32.12%	34,459	42,847	19.6%
Lawrence	87,904	10,040	2,973	29.61%	9,647	11,703	17.6%
Lebanon	130,620	11,137	3,461	31.08%	9,529	12,394	23.1%
Lehigh	342,301	37,342	13,163	35.25%	30,792	39,337	21.7%
Luzerne	309,200	37,719	11,646	30.88%	32,531	40,197	19.1%
Lycoming	111,129	13,619	3,782	27.77%	11,121	13,586	18.1%
McKean	40,039	5,620	1,414	25.16%	4,947	5,968	17.1%
Mercer	108,854	12,661	3,376	26.66%	12,754	14,745	13.5%
Mifflin	46,069	6,182	2,135	34.54%	5,258	6,076	13.5%
Monroe	1,652,202	18,346	6,058	33.02%	13,367	16,916	21.0%
Montgomery	784,202	42,464	12,968	30.54%	37,112	49,471	25.0%
Montour	17,757	1,591	535	33.63%	1,530	1,731	11.6%
Northampton	287,113	23,693	6,574	27.75%	19,803	26,034	23.9%
Northumberland	89,852	11,163	3,911	35.04%	9,552	11,684	18.2%
Perry	45,061	3,578	1,243	34.74%	2,739	3,431	20.2%

Philadelphia	1,493,745	316,952	88,696	27.98%	271,486	326,473	16.8%
Pike	56,414	5,000	1,851	37.02%	3,399	4,750	28.4%
Potter	17,170	2,158	683	31.65%	1,791	2,151	16.7%
Schuylkill	140,177	15,852	5,023	31.69%	14,586	17,632	17.3%
Snyder	37,314	3,749	1,363	36.36%	2,855	3,482	18.0%
Somerset	73,042	7,655	2,429	31.73%	6,736	8,437	20.2%
Sullivan	6,251	819	218	26.62%	614	733	16.2%
Susquehanna	42,366	5,232	1,779	34.00%	3,067	3,795	19.2%
Tioga	40,492	5,282	1,754	33.21%	3,568	4,638	23.1%
Union	35,729	4,115	1,127	27.39%	2,420	2,837	14.7%
Venango	53,342	6,750	1,822	26.99%	6,096	7,127	14.5%
Warren	40,440	4,450	1,404	31.55%	3,782	4,496	15.9%
Washington	203,179	19,634	5,390	27.45%	16,058	19,672	18.4%
Wayne	48,554	5,162	1,481	28.69%	4,309	5,347	19.4%
Westmoreland	355,924	32,778	8,284	25.27%	30,054	36,533	17.7%
Wyoming	27,394	2,892	727	25.14%	2,142	2,740	21.8%
York	427,140	36,311	12,672	34.90%	28,100	37,327	24.7%

Source: U.S. Census Bureau, American Community Survey, 2011–2016.

NOTES

1. The ACA extends Medicaid coverage to individuals living at 133% of the FPL, but requires states to apply a 5% income disregard in determining eligibility, effectively bringing minimum eligibility requirements to 138% of the federal poverty level.

2. In response to mandated Medicaid expansion and to the "individual Mandate" provisions of the ACA requiring individuals to obtain health insurance or face a tax penalty, 26 states and the National Association of Independent Businesses sued the federal government. The states were Alabama, Alaska, Arizona, Colorado, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Pennsylvania, Ohio, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin, and Wyoming.

3. Others include Arkansas, Maine, Oklahoma, Tennessee, and Wyoming. Of these, only Arkansas is reforming Medicaid and it is doing so through a Section 1115 Waiver, rather than the ACA expansion. Pennsylvania is the only mixed or hybrid state to have adopted the ACA Medicaid expansion.

4. A handful of additional states pursued similar state-run privatized alternatives for expanding Medicaid, including Arkansas, Iowa, Michigan, and Tennessee.

5. These individuals are referred to as PCO beneficiaries because they receive care through private managed plans. Eligibility under Corbett's Private Coverage Program was limited to individuals ages 21–64 with incomes up to 133% of the federal poverty level, including childless adults and those with incomes greater than 33% FPL, which was previously the income cap for Medicaid in Pennsylvania. Existing Medicaid recipients were funneled into one of two new managed plans: a high-risk pool enrolling pregnant women, SSI beneficiaries, and those eligible for Medicare and Medicaid; and a low-risk pool offering more limited medical services. Newly eligible adults not determined to be "medically frail" were enrolled in the Private Coverage option.

6. The CMS project stipulated that cost sharing and premium contributions could not exceed 5% of family income.

7. Marilyn Tavenner, Secretary, Federal Department of Health and Human Services to Beverly Mackereth, Secretary of the Pennsylvania Department of Public Welfare, August 28, 2014.

8. Prior to the ACA, states were already required to provide coverage at higher levels to children and pregnant women.

9. Some 19- and 20-year-old adults without children with incomes up to 33% FPL previously were eligible for coverage.

10. Press Release 2015.

11. One limitation is that for the purposes of Medicaid eligibility in the state of Pennsylvania, adults are considered individuals ages 21–64. The Census data on poverty and the uninsured, however, defines adults as those ages 18–64.

12. We do not estimate it here, but it is important not to underappreciate the effects of Obamacare and Medicaid expansion on individuals previously eligible for but nonetheless un-enrolled in Medicaid.

13. Prior to implementation of the ACA, county and municipal health departments could provide primary care services not available through state district offices, such as immunizations, mammograms, and dental services.

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