The Supreme Court Ruling and What It Means

BY JACK EBELER

The Affordable Care Act (ACA) established two major financing streams beginning in 2014 to help individuals and families afford health care coverage: an expansion of state Medicaid programs to include residents with income below 138 percent of the federal poverty level, and insurance premium tax credits on a sliding scale for residents with income up to 400 percent of the federal poverty level.[1]

Federal dollars fund 100 percent of the Medicaid expansion for new eligibles from 2014 through 2016. That funding phases down to 90 percent federal/10 percent state by 2019 and in subsequent years. The underlying Medicaid statute — dating back to 1965 — provides the U. S. Secretary of Health and Human Services (HHS) authority to withhold federal matching dollars if a state's plan does not comply with legal requirements.

Even before the ACA became law, several states had implemented such expansions of eligibility for adults by applying to the HHS Secretary for waivers. For those states, the ACA phases in increases until 2019, when they, like states newly covering this population, will be funded at the 90/10 ratio.

SUPREME COURT DECISION

In June 2012, when the U.S. Supreme Court ruled on challenges to the ACA, much attention focused on the individual mandate — the requirement for most people to carry a basic amount of health insurance or face a penalty. Ruling it a tax, the court upheld its use as a penalty for individuals who do not meet the ACA's health insurance requirement. But the court also ruled that Medicaid's penalty provision — withdrawal of all federal matching funds — could not be applied to states that do not expand their Medicaid population under the ACA.[2] The court decision essentially renders the Medicaid expansion a state option.

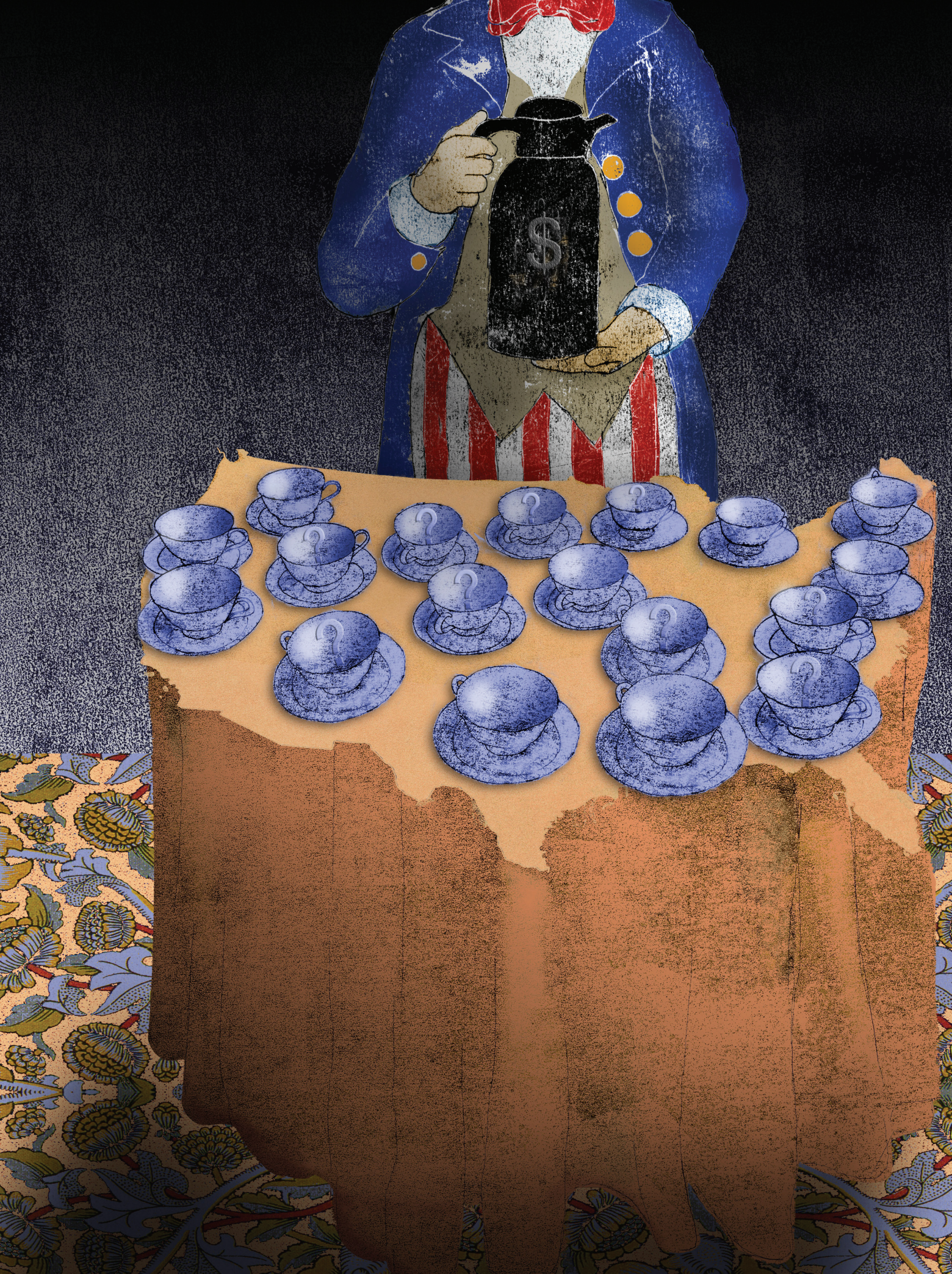
OPTIONS FOR STATES

The court left the remainder of the ACA intact, and in August 2012 — when this article is being written — states can expand Medicaid eligibility, as envisioned under the statute, by covering all those with income up to 138 percent of the federal poverty level and receive 100 percent federal funding for the first few years before the matching rate phases down to 90 percent. Urban Institute researchers estimate that there are about 15.1 million individuals who would be newly eligible under a full statutory expansion of Medicaid.[3]

The Kaiser Family Foundation provides an assessment of the characteristics and health needs of this currently uninsured, low-income population.[4] Most (69 percent) are childless adults; 31 percent are parents with children. About 1 in 6 is in fair or poor health, and one-third has a diagnosed chronic condition. They report worse access to care and receive less preventive care than those covered under Medicaid today.

The Supreme Court also made it clear that states can choose not to implement the Medicaid expansion. The implications for their residents vary, based on income level.

- 3.6 million of the newly eligible have income



between 100 and 138 percent of the federal poverty level. In a state that opts not to expand Medicaid, they could qualify for income-related tax credits or cost-sharing subsidies to help them buy basic health coverage on the state insurance exchange.

■ 11.5 million of the newly eligible have income below 100 percent of the federal poverty level. Most adults in that income level currently don't qualify for Medicaid coverage unless they are elderly, disabled, pregnant or have dependent children. If their state chooses not to participate in the Medicaid expansion, those adults at the poorest income level are likely to remain without health coverage. They do not qualify for tax credits or subsidies to help them buy basic coverage on the state insurance exchange.

It isn't clear if states have any options other than full implementation or no implementation of the Medicaid expansion. For example, can a state expand Medicaid coverage to add only those people at or below 100 percent of the federal poverty level, since the population above that income level can get financial help to buy coverage on the exchange? Or can a state phase in coverage or implement the expansion on a less than statewide basis — in some counties but not in others, perhaps?

Initial readings of the law indicate the Medicaid expansion is an all-or-nothing proposition. Still, HHS traditionally has been very open to state discretion in implementing Medicaid, and HHS Secretary Kathleen Sebelius has been particularly open to that discretion in implementing other aspects of the ACA. However, she has not yet provided any guidance on how she may deal with the states on this issue, whether by regulation or through her authority to waive requirements of the law for demonstrations and potentially allow partial Medicaid expansion. Waivers are typically subject to budget neutrality requirements that may be difficult to meet in this circumstance.

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STATE MEDICAID IMPLEMENTATION DATES

Effective Year of Implementation	Number of States	Cumulative Total
1966	26	26
1967	11	37
1968, 1969*	5	42
1970	7	49
1971	1	50
1982	1	51

*Includes District of Columbia

Source: Kaiser Family Foundation. August, 2012

PACE OF IMPLEMENTATION

It also isn't completely clear what timetable states must follow in terms of Medicaid expansion. The states are required to submit their insurance exchange blueprints by mid-November 2012, but so far there is no federal deadline for states to announce whether they will participate in Medicaid expansion. If they choose to expand Medicaid in 2014, as the ACA intended, operational realities would appear to require states to decide by mid-2013. However the Supreme Court decision also means states can decide to bring the now optional expansion on line in future years.

Given the Supreme Court's decision and differing state views about Medicaid and the ACA in general, implementation of the Medicaid expansion is going to be a state-by-state matter occurring over a multiyear period. The prospect may seem daunting, especially for the uninsured and their caregivers in states that lag behind. But Medicaid implementation has been piecemeal since its beginning, even though it is seen today as a nationwide program, operating in every state.

The Kaiser Family Foundation recently provided an update on how the original Medicaid program rolled out after its enactment in 1965. As shown in the table above, 26 states implemented Medicaid within the first year (1966), and another 11 joined in 1967. By 1972, only Arizona remained outside the program, and Arizona joined in 1982.[5]

CONGRESSIONAL BUDGET OFFICE ESTIMATE

The Congressional Budget Office (CBO) reviewed the implications of implementing the Medicaid expansion as a state option following the Supreme Court decision.[6] In brief, CBO notes a great deal of

uncertainty, but estimates that, by 2022:

- Medicaid enrollment will increase by about 6 million fewer individuals (an increase of 11 million compared with the 17 million increase projected under a mandatory Medicaid expansion).
- Subsidized coverage in the exchanges will increase by about 3 million more (an increase of about 20 million compared with the 17 million increase estimated under a mandatory Medicaid expansion). In general, the 3 million will be individuals with income between 100 to 138 percent of the FPL and made eligible for subsidies because they live in states that do not cover them under Medicaid.
- About 3 million additional individuals will be uninsured (an uninsured population of 30 million compared with the 27 million uninsured projected under a mandatory Medicaid expansion).

CBO does not make state-by-state projections but assumes phased implementation over several years, with two-thirds of the newly covered coming into the Medicaid program in states that take advantage of the coverage option in 2014 and 2015. The remainder comes in over the next few years, but about one-sixth of the potential Medicaid eligibles are left uncovered by 2022, as noted above.

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THE IMPORTANCE OF INSURANCE COVERAGE

In a 2009 report, the Institute of Medicine (IOM) updated a rigorous review of the published literature on what it means to lack health insurance.[7] The findings confirm what individuals, families and caregivers know from first-hand experience: Coverage matters. Uninsured adults, for example, are less likely to receive clinical preventive services, and they are more likely to be diagnosed with later-stage breast, colorectal or other cancers that are detectable by screening or symptom assessment by a clinician. As a consequence, when uninsured adults are diagnosed with such cancers, they are more likely to suffer poor outcomes or die.

Research since that IOM report provides new evidence on the benefits of Medicaid coverage for those who would otherwise be uninsured, and it is especially relevant for the coverage group of uninsured adults at risk as states decide whether to participate in the Medicaid expansion.

One study compared three states that in the past had substantially expanded adult Medicaid eligibility with three neighboring states that had not implemented such an expansion.[8] It found that the Medicaid expansions were associated with increased rates of Medicaid coverage and decreased rates of uninsurance; a reduction in adjusted all-cause mortality, with the reductions greatest among older adults, nonwhites and residents of poorer counties; decreased rates of delayed care because of costs; and increased rates of self-reported health status of excellent or very good.

A second study is from the Oregon Health Study Group. Oregon opted to conduct a lottery to allocate a limited number of Medicaid coverage slots for low-income adults. That presented an unprecedented opportunity to assess the implications of coverage based on the gold standard for research — a randomized, controlled trial. The research has just begun, but two of the lead researchers summarized the first year's findings in the *New England Journal of Medicine*.[9]

- Use and costs: Those with Medicaid coverage had higher use, and a 25 percent increase in total health spending
- Primary and preventive care: Those with coverage were 70 percent more likely to report a regular source of care and more likely to have received recommended clinical preventive services. They were, for example, 60 percent more likely to have a mammogram and 20 percent more likely to have a cholesterol screening.
- Self-reported health: Those with coverage were 25 percent more likely to indicate they were in good, very good, or excellent health (instead of fair or poor health).
- Finances: Those with coverage were 40 percent less likely to have borrowed money or stopped payment of another bill as a result of medical expenses and 25 percent less likely to have unpaid medical bills sent to a collection agency.

In its report on finances, the study also brings providers into the picture. It notes that the financial benefits of coverage accrue not just to the family of the uninsured, but to the providers that serve them as well. Bills sent to a collection agency for people without health coverage are, in fact, rarely collected, so the costs of a lack of insurance are spread to the providers that serve this population.

That provider linkage with the costs of uninsurance and the benefits of better coverage is especially relevant in pursuing the Medicaid coverage option in states, given the trade-offs involved in enacting the ACA. As with any major legislation, there were difficult choices for those supporting the long-standing goal of improving coverage. Congress and the president were committed to legislation that did not add to the deficit (the final bill actually reduced the deficit), so the cost of the new coverage expansion had to be paid for. That required savings, largely in the form of reductions in the rate of increase in Medicare payments, and new revenues.

The spending reductions focused on Medicare payments to providers and health plans, with hospitals a key savings target. The CBO estimated at the time that limits on Medicare hospital payments totaled about $155 billion over the 10-year period. Because the coverage expansion would, in theory, lessen somewhat the demand for hospitals to provide uncompensated care, the Medicare savings included $22 billion in reductions in the disproportionate share hospital (DSH) payments, and Congress added another $14 billion in reductions in Medicaid's DSH program payments.

Thus, Catholic health care and other advocates achieved a major step toward a long-standing goal of improved coverage for the most vulnerable in the community, paid for in part through financial constraints in other aspects of their operations.

The difficulty, of course, is for those in a state that does not implement the Medicaid expansion and leaves some residents without coverage, while the rest of the program, including the Medicare and Medicaid cuts, remain in place. In that case, the caregivers who serve this population and will continue to serve them, lose some of the necessary financing for the care that they provide.

The Medicaid expansion will be a critical issue for states in the coming years, and it can be expected to be delayed in some states. Ultimately, the states' decisions should be supported by the needs of these individuals in the community, the increasingly well-documented benefits of Medicaid coverage and the critical importance of assuring financing for the providers who care for them — along with the availability of generous federal matching.

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NOTES

1. The law calls for coverage up to 133 percent of the federal poverty level, plus another 5 percentage points to account for a standard income disregard, so this article uses the 138 percent total figure. The federal poverty level for 2012 is $11,170 for an individual and $23,050 for a family of four.

2. *National Federation of Independent Business, et al. v. Kathleen Sebelius, Secretary of Health and Human Services, et al.*, Supreme Court of the United States, June 28, 2012, www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf.

3. Genevieve M. Kenney et al., *Opting Out of the Medicaid Expansion Under the ACA: How Many Uninsured Adults Would Not Be Eligible for Medicaid?* (Washington, D.C.: Urban Institute Health Policy Center, July 2012) www.urban.org/publications/412607.html.

4. Kaiser Family Foundation, *Expanding Medicaid under Health Reform: A Look at Adults at or below 133 Percent of Poverty* (Menlo Park, Calif.: 2010) www.kff.org/healthreform/upload/8052-02.pdf.

5. Kaiser Family Foundation, *A Historical Review of How States Have Responded to the Availability of Federal Funds for Health Coverage* (Menlo Park, Calif.: 2012) www.kff.org/medicaid/8349.cfm.

6. Congressional Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision* (Washington, D.C.: 2012) www.cbo.gov/publication/43472.

7. Institute of Medicine, *America's Uninsured Crisis: Consequences for Health and Health Care* (Washington, D.C.: The National Academies Press, 2009) www.iom.edu/Reports/2009/Americas-Uninsured-Crisis-Consequences-for-Health-and-Health-Care.aspx.

8. Benjamin M. Sommers, Katherine Baicker and Arnold M. Epstein, "Mortality and Access to Care among Adults after State Medicaid Expansions," *New England Journal of Medicine* online (July 25, 2012) www.nejm.org/doi/full/10.1056/NEJMsa1202099.

9. Katherine Baicker and Amy Finkelstein, "The Effects of Medicaid Coverage — Learning from the Oregon Experiment," *New England Journal of Medicine* 365 (Aug. 25, 2011): 683-685.

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