Understanding the ACA Supreme Court Decision: State Decisions and State Solutions

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General Summary
The U.S. Supreme Court (hereinafter “Court”) found the Affordable Care Act (ACA) constitutional in part and unconstitutional in part. The individual mandate was found to be consistent with Congress’s power to tax as it penalizes those with a certain amount of income that choose to go without insurance. More surprising was the Court’s decision to declare the ACA’s Medicaid expansion voluntary for states and preclude the federal government from withdrawing a state’s entire Medicaid funding because it threatened states with an “economic dragooning” that left them no choice but to participate.

In upholding the vast majority of the Affordable Care Act, the Court ensured that some of the key provisions will either continue to be in effect, or will be taking effect starting January 1, 2014. These include:

- Prohibition on health plan rescissions (retroactive cancellation of coverage)
- Guaranteed Issue (requirement to offer coverage regardless of health status, age or medical condition)
- Rating Standards (premiums can only vary for family size, geographic rating area, age and tobacco use, with a maximum allowable variation in the age factor of 3:1 and 1:1.5 for tobacco use)
- Rate Review (regulatory oversight of premiums and justification of “unreasonable” increases)
- Health Insurance Exchanges
- Temporary High Risk Pools
- Medical Loss Ratio limit (85% for large group and 80% for individual and small group markets)
- Preventive Screenings (requirement for plans to cover USPSTF A and B-rated recommendations, immunizations, HRSA guidelines for preventive care and screening for children/women)
- Coverage for Children to Age 26
- Ban on lifetime/annual limits
- Essential Health Benefits/Limits on Cost-Sharing
- Premium tax subsidies for individuals and families below 400% of federal poverty level
- Small business tax credit for employers that offer coverage
- Large employer requirements to offer coverage or pay a per-employee fee
- Basic Health Plan option
- Health care quality, IT and public health interventions
- Community Transformation Grants
- Nutrition labeling
- Workforce Development grants
- Fraud and Abuse Prevention/Reporting
- Licensure of biosimilar products
- Medicare payment reform and quality adjustments
Improved coverage for the Medicare Part D Coverage Gap (aka “Donut Hole”)
- Linking hospital payments to quality measures/payment reforms
- Accountable Care Organizations
- Coordination of care for Medicare/Medicaid Dual Eligibles

**Medicaid Expansion Decision**

The Court agreed with the twenty-six states challenging the ACA that loss of existing Medicaid funding was an unconstitutional sanction because it ran counter to the nation’s system of federalism and “would threaten the political accountability key to our federal system.” Specifically, Chief Justice Roberts argued that “where the Federal Government directs the States to regulate, it may be state officials who will bear the brunt of public disapproval, while the federal officials who devised the regulatory program may remain insulated from the electoral ramifications of their decision.” While other Congressional actions have offered financial support to states and threatened the loss of funding if states refused to comply, the Court found that the ACA’s financial “inducement” was “more than relatively mild encouragement” but “a gun to the head.” Citing *South Dakota v. Dole*, the Court pointed out that in some instances, the threat of withholding state funds was justified, but not impermissibly coercive and only offered “mild encouragement” to the states to comply. In *South Dakota*, Congress threatened to withhold 5% of state highway funds if the state refused to raise its drinking age to 21. Since the federal funds were less than half of one percent of South Dakota’s budget at the time, the Court found that this Congressional requirement was not unduly burdensome on the state and if officials refused to raise their drinking age, they were allowed to do so.

Another argument that bolstered the Court’s decision to find the Medicaid expansion unconstitutional was the extensiveness of the expansion itself. Unlike previous changes to the Medicaid program that merely altered or expanded the basic four eligibility categories (disabled, blind, elderly and needy families with dependent children), the ACA “transforms” Medicaid into a program that meets the health care needs of an entire nonelderly population with income below 138% of the federal poverty level. The Court agreed with the states that the Medicaid expansion was structured and funded differently than the current Medicaid program. Thus, Congress was explicitly creating a separate program with distinctive funding requirements. Justice Ginsburg argued that the Medicaid expansion was no different than previous changes, but the majority opinion ultimately found that Congress cannot penalize states that choose to decline participation in the Medicaid expansion since the ACA represented a fundamental change in the scope and nature of the Medicaid program.

**General Observations:** In preserving the ACA with the exception of the specific sanction for states that choose to not participate in the Medicaid expansion to 138% of the federal poverty level, the Court placed the bulk of the responsibility for ACA implementation back with the states. While the media has tried to highlight and sensationalize the states that will not participate, HMA believes that most, if not all states will implement the various provisions of the Affordable Care Act. However, each state will implement in a manner that is tailored to their individual timeframe for implementation and political environment. Other factors that will significantly impact a state’s implementation will be the size of the uninsured population, the needs of the state’s provider community and the existing state Medicaid
program. Each state will now have an opportunity to engage with the federal Centers for Medicare and Medicaid Services (CMS) on what kind of flexibility a state will be allowed to implement the Medicaid expansion, either through a series of state plan amendments, waivers or a combination of both. While it is expected that the federal government will establish limits or requirements on states that seek to expand the Medicaid program consistent with the Affordable Care Act, it will also be more likely for states to counter those requirements with their own requests and need for greater flexibility and seek approval to cover these expansion populations with a different benefit package or through a phased-in approach.

Questions and Outstanding Issues: With only eighteen months until the main coverage provisions of the Affordable Care Act are operational, states will be looking to the federal government for a series of guidelines and regulatory actions to help in their implementation activities. While CMS and other federal agencies have been publishing draft regulations, issuing grants and providing technical assistance to states since the passage of the Affordable Care Act in 2010, there are a number of areas in which states will be increasingly aggressive in seeking guidance in order to make some of the critical choices and fundamental decisions in their state agencies and legislatures. Some of these decisions will derive from the questions below:

- What will the federal government do to provide coverage to individuals in a given state if the state rejects the Medicaid expansion funding? Will CMS be able to cover those individuals through a different mechanism?
  - Comment: Individuals with incomes exceeding 100% FPL may elect subsidized exchange coverage in lieu of Medicaid. For states that choose not to operate a health insurance exchange, the federal government will offer coverage through a federally-operated health insurance exchange. Some states may not be able to make the deadline for operational readiness by 2013, and will instead seek a “partnership model” with CMS for an initial period of time with a longer-term goal of a state-operated exchange.

  For individuals with income over 100% FPL that purchase coverage through a state or federal exchange, this will dramatically impact their cost-sharing and benefits that would have otherwise been available for no cost under the Medicaid program. For individuals with incomes below 100% FPL, it is likely that they will receive the same treatment as legal immigrants with less than 5 years of residency and income below 100% FPL. The ACA allows for these legal immigrants to purchase coverage through an exchange with their subsidies calculated as if their income was at 100% FPL. In spite of this possible scenario, it is likely that many will continue to find coverage unaffordable.

- Will states be allowed to participate the first 3 calendar years (2014-2016) at 100% federal funding and then return eligibility levels to their previous level when the funding phases down?
  - Comment: HMA believes that CMS will be strongly opposed to this, but states may seek on a case-by-case basis to implement their Medicaid expansion through a waiver or waiver amendment. Those waiver terms and conditions would be subject to negotiation between the particular state and CMS.
will CMS allow states to expand their Medicaid populations through a waiver?

Comment: While CMS will need to issue guidance to states on how they will be administratively addressing the Medicaid expansion issues raised by the Court’s decision, one possible route to expanding coverage would be through a waiver. These waivers could target coverage at a lower income level (i.e., up to 100% of FPL), target a subset of an expansion group (i.e., parents) or allow expansion to happen in select geographic regions of a state (such as the county low-income health programs approved under California’s 1115 waiver). CMS may also allow changes in benefit package and delivery systems, but will be likely requiring states to continue demonstrating adequate beneficiary protections and other types of waiver requirements as a condition for approving such flexibility.

Will the new Medicaid eligibility rules apply only to states that agree to participate in the Medicaid expansion – or will they be applied to all states regardless of their participation?

Comment: The Court’s decision only invalidated the ability of CMS to sanction the states for not participating in the Medicaid expansion. All of the other changes in the Medicaid program remain in effect, so HMA believes that states will, starting January 1, 2014, be required to use the new eligibility standards and application requirements, regardless of whether they expand eligibility or not. For example, non-elderly non-disabled individuals will no longer be subject to any asset or resources test and may self-certify their income. These eligibility changes in Medicaid, on their own, represent significant changes to the program and will allow many individuals to enroll in a more expeditious and efficient manner.

If an individual is eligible for Medicaid under the ACA (under 138% FPL) but lives in a state that has refused to participate in the Medicaid expansion, is it possible the individual will be subject to the individual mandate penalty?

Comment: This is highly unlikely, given the income of the individuals under 138% FPL (based on the 2012 Federal Poverty Guidelines, an individual with an annual income of $14,856 is at 133% of the FPL). The Affordable Care Act lists the individuals for which the tax penalty will not apply, including those who were not covered for a period of less than three months; had a contribution for a calendar year that exceeded 8% of the individual’s household income; had a taxable income of less than 100% FPL; is a Native American; or has a hardship exemption. In addition, Secretary Sebelius released a letter to all state Governors on July 10 that stated the federal government’s intention to exercise its statutory authority to establish additional hardship exemptions as necessary.
• Which states have the largest populations of uninsured below 138% FPL?
  o California – 2.456 million individuals
  o Texas – 2.036 million individuals
  o Florida – 1.552 million individuals
  o Georgia – 843,000 individuals
  o New York – 811,000 individuals

(Data from the Urban Institute Health Policy Center/“Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults Would Not Be Eligible for Medicaid?” July 5, 2012)

What Should States Be Analyzing? States have been, and will continue to be, critical participants in implementing the various provisions of the Affordable Care Act. Understanding the fiscal and programmatic changes in a state Medicaid program, as well as the cascading effects on a state’s population, safety-net providers, and broader health plan community is going to be important in the coming weeks and months leading up to 2014. Some of the key questions that state Medicaid programs and stakeholders should be asking:

• What is each state’s expected population under the Medicaid expansion versus the current program? (Within the projected enrollment increase, what are the “new eligible” numbers and the “old eligible” numbers?) Understanding these numbers to the greatest degree of accuracy possible will allow states to understand what their fiscal costs will be for the “old eligible” categories starting in 2014.

• What type of cost would each state incur starting in 2017 when the federal funding drops from 100% to 95% (94% in 2018, 93% in 2019 and 90% in 2020 and annually thereafter)? Cost calculations will also need to include the “old eligible” populations that were eligible for Medicaid prior to the ACA, but not enrolled, in addition to the costs for the “new” populations. These two populations will receive different federal funding levels and states will be paying a larger share of the “old” eligible population at their established FMAP rate.

• Will CMS allow states to phase enrollment of the now-optional expansion populations into their existing Medicaid program and under what FMAP rate?

• For states with significant costs due to populations that churn between the correctional system (local jails or prison) because of mental illness and/or drug and alcohol addiction, the Medicaid expansion offers an opportunity to reduce costs to a state or local jurisdiction’s public safety budget based on the ability of individuals to receive behavioral health services as mandated under the ACA. To the extent possible, states may want to consider analyzing this possible cost-saving or cost-avoidance.

• If a state chooses to participate in the Medicaid expansion, what state-only programs can be eliminated or significantly reduced after individuals receive coverage through either Medicaid or a health insurance exchange? What optional Medicaid populations can become “new eligibles” and move to 100% Federal funding? Are states considering using existing general fund for state-only programs as match for the Medicaid expansion?
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- What are the practical and funding implications for expanding a state’s Medicaid population through a waiver versus a state plan amendment?
- What would a Basic Health Plan or “Tennessee Bridge” option offer to a state that is interested in covering a population and reducing churn, but limiting its fiscal exposure?
- Since the ACA has been upheld with the exception of part of the Medicaid expansion, hospitals will be facing Disproportionate Share Hospital allotment reductions totaling $14.1 billion in FFY 2014 through FFY 2019, plus an additional $4 billion in FFY 2020. For states that choose to forego participation in the Medicaid expansion, these hospitals will not only continue to see the uninsured/medically indigent, they will also be losing funds that have traditionally been directed to these hospitals that treat the uninsured. The pending DSH cuts will have deeper impact in states that do not expand their Medicaid program and policymakers will need to consider these fiscal issues.
- In order to reduce long-term fiscal exposure, states may consider expanding their Medicaid eligibility up to 100% of the federal poverty level (the level at which the subsidies start in the health insurance exchanges) and allowing those over 100% FPL to seek coverage in a health insurance exchange at no cost to the state.
- Recall that under the Affordable Care Act, states with fully-operational health insurance exchanges, as determined by the Secretary, will no longer have a Medicaid maintenance-of-effort (MOE) in place that restricts their eligibility standards, methodologies or procedures (with the exception for children under the age of 19 through September 30, 2019). States that choose to operate a health insurance exchange may re-introduce administrative requirements for enrolling in public health insurance programs – requirements that are currently prohibited under MOE rules.

Summary and Conclusions
The passage of the Affordable Care Act in 2010 was an important milestone in the national debate on how to improve our health delivery system. For the past two years, states have engaged in a variety of planning activities that ranged from aggressive implementation to extremely cautious. With the debate over the Act’s constitutionality now settled by the U.S. Supreme Court, state policymakers have a significant number of analyses and decisions to make for how to best implement the provisions of the ACA for their state citizenry, and what these decisions will mean for their health care providers and broader community. A solution in one state will not represent a solution for two, thirteen or even forty-nine other states. HMA believes that the Affordable Care Act’s Medicaid expansion and concomitant program changes represent the most significant change since the program was enacted in 1965. Just as each state decided on how to best implement Medicaid over 40 years ago, it remains true in 2012.
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