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Health Reform

N-2 Supreme Court Ruling's Impact on Affordable Care Act Medicaid Expansion

The Patient Protection and Affordable Care Act and the Health Care Education Act, jointly referred to as the Affordable Care Act (ACA), passed in March 2010, included a section which addressed the expansion of the Medicaid program.

Eligibility Requirements

To participate in Medicaid, states were required by federal law to cover the following groups: pregnant women and children under the age of six with family incomes below 133 percent of the federal poverty level (FPL), children ages six through eighteen with family incomes at or below 100 percent of FPL, parents and caretaker relatives who met certain financial eligibility guidelines, and elderly and disabled individuals who qualified for Supplemental Security Income benefits as a result of low income and resources.

The Medicaid expansion for adults, scheduled to commence on January 1, 2014, in conjunction with the health insurance exchange, was structured to extend Medicaid coverage to a newly eligible group consisting of nearly all non-disabled adults under the age of 65 whose household income fell at or below 133 percent of the FPL with a variance of plus or minus 5 percent. Under the 2012 Federal Poverty Level, a family of four making $30,657 and an individual making $14,856 would be at 133 percent FPL. A family of four making $31,809 and an individual making $15,415 would be at 138 percent FPL.

Federal Government Funding

Under the ACA provisions, states were required to participate in the Medicaid expansion for the newly eligible group or risk losing all Medicaid funding. Instead of providing federal matching funds to the states to provide Medicaid covered services to the new group under the existing federal share structure, known as the medical assistance percentage (FMAP), the federal government would cover 100 percent of the states' costs for the newly expanded group from 2014 through 2016 and gradually reduce the federal share to 90 percent in 2020 and after.

The provisions of the federal Medicaid Act that grant authority to the Secretary of the Department of Health and Human Services (HHS) to withhold all or part of a state's federal matching funds for non-compliance with federal requirements were unchanged by the ACA.

Court Challenge to Medicaid Expansion

Twenty-six states, several individuals, and the National Federation of Independent Business (NFIB) brought suit in Federal District Court challenging the Medicaid expansion and the constitutionality of the individual mandate. The case is known as *Florida v. HHS*. At least 25 other cases were filed in federal district courts, but only in the Florida case did the petitioners assert that the ACA's Medicaid expansion was "unconstitutionally coercive." Both the Florida Federal District Court and the 11th Circuit Court of Appeals upheld the Medicaid expansion provision. The 11th Circuit's decision stated states have a choice to participate in the Medicaid program and the Medicaid expansion was within Congress' spending clause power to impose conditions on its grants to states. The case reached the U.S. Supreme Court, which heard oral arguments in the case on March 26, 27, and 28, 2012. The Supreme Court's decision in the case is cited as *National Federal of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al.,* 132 S. Ct. 2566 (2012).

Arguments Before Supreme Court

Among the four issues addressed by the Supreme Court was whether Congress unconstitutionally coerced the states into expanding the Medicaid program by threatening to withhold the states' federal funding.

The state petitioners argued Medicaid expansion was coercive because the states felt the need to participate in the program due to the importance of Medicaid funding and would then be required to comply with the new expansion requirements. The states asserted Congress may not coerce the states to adopt policies through the Spending Clause of the Constitution when Congress does not have power to force the states to do so directly. The state petitioners argued that limits should be placed and enforced on Congress' spending power to protect state sovereignty and restore the balance of power between Congress and the states. The states stressed the Medicaid expansion was unprecedented because Congress had never mandated what they believed was an across-the-board Medicaid financial eligibility floor.

In the Supreme Court case, the federal government argued Congress has the authority to place conditions of the receipt of federal funds by the power granted under the Spending Clause of the Constitution. Further, the federal government argued the Supreme Court has recognized Congress' power to attach conditions on the receipt of federal funds disbursed under its spending power. The federal government also argued that federal Medicaid statute has contained mandatory coverage requirements for participating states and Congress previously has required states to cover new categories of individuals.

State Options for Medicaid Ruling Summary

The U.S. Supreme Court upheld nearly all of the ACA, affirming the law's mandate that most everyone carry insurance, but striking down a provision that would have allowed the federal government to withhold all Medicaid funds to any state that did not comply with new Medicaid eligibility requirements.

A majority of the justices voted that the government could not compel states to expand Medicaid by threatening to withhold federal money to existing Medicaid programs. “When, for example, such conditions take the form of threats to terminate other significant independent grants, the conditions are properly viewed as a means of pressuring the States to accept policy changes.” 132 S. Ct. at 2604.

The Court ruling limited the Medicaid expansion provisions but did not invalidate them. The Medicaid expansion is now optional for states, and states will no longer be required to implement those provisions. “Nothing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that States accepting such funds comply with the conditions on their use. What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding.” 132 S. Ct. at 2607.

The Court upheld the ACA’s major expansion of the joint federal-state Medicaid health insurance program but limited the possible penalty for states that opt to forgo expansion provisions outlined in the law. “The Court today limits the financial pressure the Secretary may apply to induce States to accept the terms of the Medicaid expansion. As a practical matter, that means States may now choose to reject the expansion; that is the whole point.” 132 S. Ct. at 2608.

Section 1396c of the Medicaid Act provided that if a State’s Medicaid plan does not comply with the Act’s requirements, the Secretary of Health and Human Services may declare that “further payments will not be made to the State.” 42 U. S. C. §1396c. A State that opts out of the Affordable Care Act’s expansion in health care coverage stood to lose all of its Medicaid funding. Section 1396c gave the Secretary of Health and Human Services the authority to withhold all “further [Medicaid] payments... to the State” if it is determined that the State is out of compliance with any Medicaid requirement, including those contained in the expansion. 42 U. S. C. §1396c.

“[T]he Secretary cannot apply §1396c to withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion.” Section IV-B, page 56 Opinion of Roberts, C.J.

The expansion is valid if the penalty is limited to the loss of new funds. The ACA’s provision withholding all Medicaid funding from any state that did not agree was unconstitutionally coercive on the states. “The threatened loss of over 10 percent of a State’s overall budget, in contrast, is economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion.” 132 S. Ct. at 2605.

Congress had not revised an existing program but essentially created a whole new one, and therefore was not entitled to withhold longstanding funding for states that would not go along with the changes. “[T]he manner in which the expansion is structured indicates that while Congress may have styled the expansion a mere alteration of existing Medicaid, it recognized it was enlisting the States in a new health care program.” 132 S. Ct. at 2606.

Outcomes from the ruling include:

1. Congress acted constitutionally in offering states funds to expand coverage to millions of new individuals; “Congress may offer the States grants and require the States to comply with accompanying conditions, but the States must have a genuine choice whether to accept the offer.” 132 S. Ct. at 2608.

2. States may agree to expand coverage in exchange for those new funds; "Nothing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that States accepting such funds comply with the conditions on their use." 132 S. Ct. at 2607.

3. If a state accepts the ACA-related expansion funds, it must comply with the new rules and regulations for Medicaid; "Today's holding does not affect the continued application of §1396c to the existing Medicaid program. Nor does it affect the Secretary's ability to withdraw funds provided under the Affordable Care Act if a State that has chosen to participate in the expansion fails to comply with the requirements of that Act." 132 S. Ct. at 2607.

4. A state can refuse to participate in the expansion without losing all of its Medicaid funds; instead the state will have the option of continuing its current Medicaid plan as is. "As a practical matter, that means States may now choose to reject the expansion." 132 S. Ct. at 2608.

According to Kaiser Health News, the Court's ruling on Medicaid funding took away one of the federal government's primary inducements to get states to participate in its expanded health coverage for low income people. The ACA would have allowed the government to withhold all Medicaid money to states that did not expand Medicaid coverage to those who earned up to 133 percent of Federal Poverty Level (FPL), which is about $30,000 for a family of four under the 2012 FPL. "The Court today limits the financial pressure the Secretary may apply to induce States to accept the terms of the Medicaid expansion." 132 S. Ct. at 2608.

State Decisions*

The Supreme Court's health reform ruling ends months of speculation and uncertainty, but it also raises key questions for Kansas policymakers. Among the most pressing is the question of Medicaid expansion. If policymakers choose not to comply with the eligibility changes called for in the law, an estimated 130,000 low-income adult Kansans may remain uninsured. States will now have to make a series of political, fiscal and policy decisions moving forward to determine if this Medicaid expansion makes sense for their state. Currently in Kansas, adults who are not elderly or disabled and who are not caretakers are not eligible for Medicaid at any income level. Adults who are caretakers with incomes up to roughly 27 percent of FPL—around $6,000 per year—are eligible for Medicaid.

The ACA originally required states to expand eligibility for their Medicaid programs to all non-elderly individuals with incomes up to 133 percent of FPL— about $30,000 for a family of four. The Court's decision prohibiting the federal government from withholding Medicaid funding from states that do not comply with the Medicaid expansion requirement has the effect of making the expansion optional. Of the approximately 351,000 uninsured Kansans, 151,000 could qualify for the expanded Medicaid program if implemented by the State. Of those, an estimated 130,000 are low-income adult Kansans who today do not qualify for Medicaid and who would be made eligible by the expansion. There are many questions to contemplate as Kansas weighs the decision of whether to expand the Medicaid program:

- **Should the State not opt to expand Medicaid, how many of the 130,000 Medicaid expansion population would be subject to the individual mandate?**

  A person is exempt from the individual mandate if he or she cannot find coverage for less than eight percent of his or her annual income; for a family of four earning $30,000 (133 percent of FPL), that is $2,400 yearly or $200 per month. Theoretically, many in this population would be unable to find "affordable" coverage and would be exempt from the mandate.

- **How will DSH payment reductions apply?**

  The ACA begins lowering what are known as "Disproportionate Share Hospital" or "DSH" payments in 2014. These are payments made to hospitals to help offset the costs of providing care to uninsured and low-income patients. The payments are being reduced under the theory that, as more people get insurance through the ACA, DSH payments will become less necessary. The reductions are set to be calculated based on the states' rate of uninsured, but it is not clear how calculations will be made in states that do not expand the Medicaid program.

- **Can the State High Risk Pool accommodate more persons when the Federal High Risk Pool ends in 2014?**

  In Kansas, the Federal High Risk Pool has around 300 enrollees, but the State High Risk Pool has over 2,000. Given the relative expense of the State High Risk Pool plans, this option may be too costly for persons who could be eligible for Medicaid under the expansion. Also, in its current form, the State High Risk Pool only accepts those who already have a medical condition.

- **What federal funding would be provided to states for Medicaid expansions?**

  If Kansas chose to expand the Medicaid program, the federal government would cover the cost of the newly eligible enrollees for the first three years. Over time, the federal government's share would drop to 90.0 percent.

Year	Federal share	State share
2014	100%	0
2015	100%	0
2016	100%	0
2017	97%	3%
2018	95%	5%
2019	93%	7%
2020 and beyond	90%	10%

Other States Plans

Early Adopters of Expansion

Some states have already planned for and implemented the Medicaid expansion.

Table 2

States Getting an Early Start on the Medicaid Expansion, April 2010-May 2012

	Coverage Authority	Effective Date	Income Limit	Enrollment
CA	Waiver	Nov 1, 2010	200% FPL	251,308
CT	ACA Option	April 1, 2010	56% FPL	74,752
CO	Waiver	April 1, 2012	10% FPL	10,000
DC	ACA Option Waiver	July 1, 2010 Dec 1, 2010	133% FPL 200% FPL	40,776 3,411
MN	ACA Option Waiver	March 1, 2010 August 1, 2011	75% FPL 250% FPL	80,200 41,811
MO	Waiver	July 1, 2012	133% FPL	N/A
NJ	Waiver	April 14, 2011	23% FPL	53,490
WA	Waiver	Jan 3, 2011	133% FPL	50,920

Kaiser Family Foundation

Some States Resist Expansion

Florida, Texas, and at least a half dozen other states have said they may walk away from the nearly $1 trillion in federal funds. As outlined in the ACA, for the first three years of the expansion, the federal government will pay for 100 percent of the costs of covering the newly eligible Medicaid population. However, that federal contribution declines to 90 percent by the year 2020, with the state picking up the remaining 10.0 percent.

Governors in Wisconsin and Louisiana have said they would wait for the results of the November elections before deciding whether to expand Medicaid.

State Budget Concerns with Expansion

Matt Salo, Executive Director of the National Association of Medicaid Directors has said, while politics is a factor, states have legitimate budget concerns. Many state officials already are struggling to pay for the entitlement program, which typically is the largest or second largest state expense. A state's future share may sound small, but it represents billions in new spending that could require cutbacks of other more popular programs, such as education or transportation, or require raising taxes.

The Congressional Budget Office projected states would pay approximately $73 billion, or 7.0 percent of the cost of the Medicaid expansion between 2014 and 2022, while the federal government pays $931 billion, or 93.0 percent.

Concerns over start-up costs, the likelihood that millions of unenrolled persons currently eligible for Medicaid will enroll as a result of publicity about the expansion, and the potential that a deficit-focused Congress will scale back the federal share are causing states to evaluate whether they should opt for the expansion .

The woodwork effect—the possibility those currently Medicaid eligible individuals will enroll due to publicity about expansion—is of particular concern because states only will receive the traditional federal funding match, averaging 57 percent, for those individuals .

Health Care Provider Support for Expansion

Health care providers who treat low-income patients strongly support the expansion of coverage.

Richard J. Umbdenstock, President of the American Hospital Association, has said that hospitals around the country would lobby for the Medicaid expansion. “If states do not avail themselves of this opportunity,” he said, “the federal money will go to other states, and hospitals will be left with large numbers of the uninsured.” Nancy M. Schlichting, Chief Executive of the Henry Ford Health System in Detroit, said she “absolutely will lobby” for the expansion of Medicaid. (New York Times, July 2012)

According to the Kansas Hospital Association, the state’s pending decisions about Medicaid expansion also will have a substantial impact, at a time when hospitals have already surrendered significant Medicare revenue through the ACA with the expectation of expanded coverage. Reductions in Medicare and Medicaid disproportionate share payments were enacted in anticipation more persons would have personal coverage. Increased personal coverage is less certain because individuals may avoid coverage, and some states may not expand their Medicaid programs.

State Flexibility in Medicaid Expansion Participation

The Center for Medicare and Medicaid Services (CMS) has indicated there is much to consider in deciding whether to expand Medicaid, and there is no deadline by which states must make that determination. CMS stated states are expected and encouraged to look at their choices and options. CMS also stressed Medicaid expansion by states to include low income adults is voluntary. CMS indicated this means a state can decide when to expand, if to expand, and whether to terminate the expansion. Since Medicaid expansion is voluntary, if a state adopts the expansion and determines at a later time, for whatever reason, it does not want to maintain the expansion, the state also can decide to discontinue the expansion. CMS noted that all other aspects of the Medicaid expansion program remain intact, including the favorable federal match rate available, and states need to think through the costs and benefits of expansion before making a decision.

*Updated Information from U.S. Department of Health and Human Services

The U.S. Department of Health and Human Services has yet to promulgate guidance on the Medicaid expansion provision issue of how "current funding" is defined. The issues of what constitutes expansion and whether partial expansion is allowed have been addressed.

In a letter to Governors dated December 10, 2012, U.S. Department of Health and Human Services Secretary Kathleen Sebelius clarified states will not receive 100 percent federal funding for partial Medicaid expansion. Secretary Sebelius' December 10, 2012, posting on HealthCare.gov blog addresses whether receipt of 100 percent of federal matching funds is available to states choosing to expand to less than 133 percent of FPL. She clarified the law does not create an option for enhanced match for a partial or phased-in Medicaid expansion to 133 percent of poverty. Secretary Sebelius noted the U.S. Department of Health and Human Services would consider broad based state innovation waivers at the regular matching rate now and in 2017 when the 100 percent federal funding for the expansion group is slightly reduced.

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