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Supreme Court Ruling's Impact on Affordable Care Act—Medicaid Expansion

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Health Insurance Marketplaces/ Market Reforms/ Implementation

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Health Reform

M-1 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 that 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 18 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 2013 Federal Poverty Level, a family of four making \$31,322 and an individual making \$15,282 would be at 133 percent of FPL. A family of four making \$32,499 and an individual making \$15,856 would be at 138 percent of 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 Federation 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 on 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 the 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 the new Medicaid eligibility requirements.

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.

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.

“[T]he Secretary cannot apply §1396c to withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion.” 132 S. Ct. at 2607.

The expansion is valid, however, 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.

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.

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 FPL, which is about \$31,000 for a family of four under the 2013 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 ended months of speculation and uncertainty, but it also raised 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 \$31,000 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 356,000 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.

The HHS has yet to promulgate guidance on the Medicaid expansion provision issue of how “current funding” is defined, another key consideration for the State.

The issues of what constitutes expansion and whether partial expansion is allowed have been addressed. In a letter to Governors dated December 10, 2012, HHS Secretary Kathleen Sebelius clarified states will not receive 100 percent federal funding for partial Medicaid expansion. Secretary Sebelius’ December 10, 2012, posting on the 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 HHS 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.

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 \$31,000 (133 percent of FPL), that is approximately \$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 Disproportionate Share Hospital 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.

HHS’ Center for Medicare and Medicaid Services (CMS) issued the final rule on DSH reduction on September 18, 2013. The ACA requires the use of a DSH Health Reform Methodology (DHRM) to determine the percentage reduction in each annual state DSH allotment in order to meet the required aggregate annual reduction in federal DSH funding. The statute requires annual aggregate reductions in federal DSH funding from FY 2014 through FY 2020. The aggregate annual reduction amounts are as follows: \$500 million for FY 2014; \$600 million for FY 2015; \$600 million for FY 2016; \$1.8 billion for FY 2017; \$5 billion for FY 2018; \$5.6 billion for FY 2019; and \$4 billion for FY 2020.

CMS expects states that do not expand will have relatively higher rates of uninsured, and more uncompensated care than states expanding Medicaid. According to CMS, because states expanding Medicaid would likely have reductions in the rates of uninsurance, the reduction in DSH funding may be greater for those states than for states that do not expand. CMS anticipates hospitals in states that do not expand that serve Medicaid patients may experience a deeper reduction in DSH payments than they would if all states were to expand Medicaid, but those effects would not be experienced until after FY 2014 and FY 2015 based on current data reporting timelines.

As such, the DHRM proposed only for the first two years of DSH funding reductions (2014 and 2015) does not include a method to account for differential coverage expansions in Medicaid. Given the reduction on funding for Medicaid DSH in the ACA, in future rulemaking CMS intends to account for the different circumstances among states in the formula for DSH allotment reductions for FY 2016 and later, when the relevant data would be available.

CMS notes, though the rule would reduce state DSH allotments, management of the reduced allotments largely remains with the states. Given that states would retain the same flexibility to design DSH payment methodologies under the state plan and individual hospital DSH payment limits would not be reduced, CMS noted it could not predict if or how states would exercise their flexibility in setting DSH payments given their reduced allotments and the effect that would have on providers.

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

In Kansas, the Federal High Risk Pool has around 470 enrollees (as of June 30, 2013, as reported by CMS), but the State High Risk Pool has 1,305 (as of October 28, 2013, as reported by the Kansas Insurance Department). Both of these high-risk pools will terminate member coverage effective December 31, 2013, when standard health coverage is available to all individuals under the ACA, regardless of health status. Open enrollment for health insurance policies available on the Health Insurance Marketplace began October 1, 2013. Individuals may go to the Marketplace and select a new plan without having to report a pre-existing condition, with coverage beginning as early as January 1, 2014.

- 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 percent.

<u>Year</u>	<u>Federal Share</u>	<u>State Share</u>
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.

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

Kansas Action on Expansion

Kansas has not opted to expand Medicaid to date. Section 203 of 2013 SB 171 [the approved budget bill that made supplemental appropriations for FY 2013 (and FY 2014 for selected fee-funded agencies) and appropriations, including capital improvements for FY 2014 and FY 2015] addressed the issue of Medicaid eligibility expansion. Section 203 expressly prohibited the use of moneys appropriated from the State General Fund or from any special revenue fund or funds for FY 2013, 2014, and 2015, to expand eligibility for receipt of benefits under Medicaid, as provided for in the ACA, unless the Legislature expressly consented to the expansion of Medicaid services.

In addition, several concurrent resolutions and one bill were proposed during the 2013 Legislative Session addressing Medicaid expansion, either directly or indirectly, as outlined below. However, no final action was taken on any of these measures.

House Concurrent Resolution No. 5013 was proposed stating the will of the Kansas Legislature is that the State not expand Medicaid above its current eligibility levels. The resolution was heard before the House Committee on Appropriations, at which time testimony was presented both supporting and opposing the resolution, as well as testimony indicating the State should wait to see what flexibility the federal government might allow to make Medicaid expansion a Kansas-based program. The Committee recommended the resolution be adopted, but no further action was taken prior to the end of the session.

Also proposed during the 2013 Legislative Session were Senate Concurrent Resolutions (SCR) 1612 and 1613. SCR 1612 proposed Article 15 of the *Kansas Constitution* be amended to expressly reserve to the State and its citizens all powers not delegated to the United States by the *U. S. Constitution* or prohibited to the states by the *U.S. Constitution*. Health care was listed as included in these reserved powers. SCR 1613 made an application to the U.S. Congress to call a Constitutional Convention to consider an amendment to the *U.S. Constitution* with respect to states' rights. The proposed amendment stated the State and its citizens have the sole and exclusive authority to regulate directly, and to regulate indirectly through taxes, several subjects

including health care and all forms of insurance. Both resolutions were referred to the Senate Committee on Federal and State Affairs, but no hearing was held on either.

Further, HB 2032 was proposed to expand Medicaid eligibility to 133 percent of FPL effective January 1, 2014, for adults under the age of 65 who are not pregnant. However, no bill hearing occurred.

Other State Actions on Expansion

States have flexibility to start or stop the expansion, but the federal match rates paid are tied by law to specific calendar years. 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 percent.

According to CMS, as of October 24, 2013, 25 states and the District of Columbia have decided to move forward with Medicaid expansion, while 25 states are not expanding as of that date. Arkansas, Iowa, and Pennsylvania are exploring expansion alternatives.

Arkansas has submitted a Medicaid expansion Section 1115 demonstration waiver application (Arkansas Health Care Independence Demonstration) to CMS, which has received conceptual approval. As part of the final approval process, CMS accepted public comments on the proposal until September 7, 2013. The statewide demonstration would operate during calendar years 2014, 2015, and 2016. Under the proposed demonstration waiver, Arkansas would use premium assistance funds to purchase coverage within qualified health plans in its state and federal partnership exchange that are available in the individual market for certain individuals eligible for Medicaid coverage. These individuals would be either childless adults ages 19 to 65 with incomes at or below 138 percent of FPL or parents between the ages of 19 and 65 with incomes between 17 and 138 percent of FPL. Arkansas estimates approximately 225,000 individuals would be eligible for the demonstration.

Iowa also has submitted a Medicaid expansion Section 1115 demonstration waiver application, which like Arkansas would use Medicaid funds as premium assistance to purchase coverage for some newly-eligible Medicaid beneficiaries in Marketplace (or Exchange) Qualified Health Plans. Like Arkansas, Iowa proposed to make premium assistance enrollment mandatory for affected beneficiaries and would exempt beneficiaries who are medically frail. However, Iowa proposes waiving wrap-around benefit requirements. The Iowa plan would limit coverage to newly-eligible Medicaid beneficiaries between 101 percent and 138 percent of FPL and would require enrollees to pay a premium of \$20 per month, which may be waived if certain conditions are met. Additional details of the Iowa and Arkansas demonstration waiver application are available in a comparison prepared by the Kaiser Family Foundation entitled *Medicaid Expansion Through Premium Assistance: Arkansas and Iowa Section 1115 Demonstration Waiver Applications Compared* (September 18, 2013).

On September 16, 2013, Pennsylvania's Governor proposed an insurance expansion, Healthy Pennsylvania. *The Daily Pennsylvanian* reported on October 8, 2013, that a policy report had been issued. Healthy Pennsylvania would serve 520,000 currently uninsured individuals. The proposal would rely on a health insurance exchange that would allow private insurance companies to compete for enrollees, whose premiums would be subsidized by the federal government. However, unlike Medicaid, the proposal would require enrollees to pay up to \$25 per month in insurance premiums and create additional work requirements not present in Medicaid coverage. The work conditions include requiring able-bodied Medicaid beneficiaries to prove they are searching for employment, a requirement not allowed under federal law.

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 when weighing Medicaid expansion. 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 percent of the cost of the Medicaid expansion between 2014 and 2022, while the federal government pays \$931 billion, or 93 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.

The Kansas Department of Health and Environment contracted with Aon Hewitt to perform an independent analysis on the potential enrollment and costs of the ACA implementation to the State's Medicaid and Children's Health Insurance Program. The analysis, published on February 13, 2013, indicates the ACA (without Medicaid expansion) would cost the state an increase of \$513.5 million from the State General Fund for calendar years 2014 through 2023. The ACA with Medicaid expansion over the same time period would cost the state an estimated increase of \$1.1 billion from the State General Fund. The estimated cost increases for the State General Fund are lower in the early years of expansion due to the 100 percent federal share paid.

On April 5, 2013, Governor Brownback said he continues "active conversations with people" about the potential benefits and risks of expanding the State's Medicaid program. He stated "[e]xpansion would have to be addressed by the Legislature.

They would have to budget it.” He indicated concerns that the federal government eventually could shift much of the program’s costs onto states. The Governor has indicated he is aware of the federal government’s pledge to fully cover each state’s expansion cost for the first three years and to limit states’ responsibility to no more than ten percent thereafter, but that could change if federal funds were not available. Governor Brownback has not indicated whether he would decide on Medicaid expansion in 2013. (KHI News Service, April 5, 2013)

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 (AHA), 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.” (*New York Times*, July 2012) After the Obama Administration’s announcement in July 2013 of a one-year delay on the ACA requirement that medium and large employers provide insurance coverage for their workers or face fines, Mr. Umbdenstock issued a statement on behalf of the AHA on July 3, 2013, in which he noted the AHA is “concerned that the delay further erodes the coverage that was envisioned as part of the ACA. This delay comes at a time when there is significant uncertainty regarding Medicaid expansion. We will continue to work with Congress and the administration on the implementation of the law to make sure that the coverage needs for the uninsured are met.”

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) She stated the expansion will provide “needed revenue for our health system and needed coverage for the people we serve.” (*Detroit Free Press*, September 2, 2013)

A new report produced by researchers at Regional Economic Models, Inc., and George Washington University released by the Kansas Hospital Association (KHA) in February 2013, *Economic and Employment Effects of Expanding KanCare in Kansas*, estimates the federal funding associated with KanCare expansion will help create approximately 3,400 new jobs in 2014 and 4,000 new jobs by 2020. According to the KHA, the new report shows that expansion could help grow the Kansas economy and “documents the importance of Kansas carefully considering all aspects of expansion and making a decision that is best for Kansas.” The report indicates expanding KanCare could actually result in a net cost savings for the state of \$82 million from 2014-2020. Tom Bell, President and Chief Executive Officer of the KHA, stated “[a] decision to forego Medicaid expansion is more than just a decision to refuse the federal funding associated with Medicaid expansion. In fact, it amounts to additional real cuts to hospitals that are currently serving as the primary safety net for many uninsured individuals, and it comes at a time when the uncompensated care burden on the hospitals continues to grow at an alarming rate.” (KHA Media release, February 18, 2013)

State Flexibility in Medicaid Expansion Participation

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.

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