Health Economics, Policy and Law (2013), **8**, 133–137 © Cambridge University Press 2013
doi:10.1017/S1744133112000400

Medicaid after the Supreme Court decision

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In late June, 2012, the Supreme Court of the United States issued its rulings on a set of challenges to the Affordable Care Act (ACA) (so-called Obamacare). While leaving controversial parts of the Act such as the individual mandate to have health insurance intact, the Court ruled that an expansion of the Medicaid program to cover a previously uncovered group of Americans was not permissible. This ruling has shaken the health policy community in the United States and creates an uncertain future for both Medicaid and the ACA.

The Medicaid program in the United States was enacted in 1965 as Title XIX of the Social Security Act [For more on the Medicaid Program and its history see Stevens and Stevens (1974)]. It was a federal–state partnership in which the federal government would match the expenses of states according to a formula based on a state's income for certain prescribed services (which had to be provided), as well as optional services, which would be matched if the state chose to provide them.[1] The initial target audience was single mothers and their children who were already on welfare. The law included a provision (known as the spend-down provision) that allowed people who were over the income eligibility threshold to become eligible for the program if they spent enough on medical care to fall under the threshold. Through this mechanism, large numbers of the elderly in long-term care facilities became eligible for Medicaid as well and now are responsible for the vast majority of its cost.

As of June, 2011 there were 52,621,500 people enrolled in the Medicaid program in the United States. Of these, 27,000,000 were children and 25,000,000 were adults.[2] Total spending on Medicaid was $389 billion in FY 2010 of which $125 billion was from the states and the remainder from the federal government.[3] There is a wide variation in spending by population

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1 Mandatory services include doctor visits, hospitalization, lab services, nursing home care, etc.; Optional services include home care, transportation, etc. See Kaiser Commission on Medicaid and the Uninsured. "Medicaid: a Primer". June, 2010.

2 Kaiser Commission on Medicaid and the Uninsured "Medicaid and Long Term Care Services and Supports". June, 2012. Table 1, Table 3.

3 StateHealthFacts.org "United States: Medicaid Spending". Kaiser Family Foundation, 2011.

https://doi.org/10.1017/S1744133112000400 Published online by Cambridge University Press

segment with the aged responsible for 23% of total costs, the disabled 43%, adults 14% and children 21%.

While states pay only 1/3 of the total cost of the program (on average), for most states it is either their most expensive or second most expensive budget item. While many states have expanded coverage to other groups or higher income people, the largest group that remains without coverage are adults without children. This is the group that was targeted by the ACA and estimates were that 16,000,000 currently uninsured Americans would be covered under this Medicaid expansion.

The major fiscal crisis that confronted the United States in 2008 led many states to cut back their Medicaid programs in order to save money. Medicaid is countercyclical in that enrollment goes up when the economy goes down and states have the least revenue to afford the increased enrollment. Almost every state cut back the program in some way generally by reducing provider fees or optional services. At the same time the growth of a more conservative House of Representatives has sought to reduce the federal contribution to Medicaid as well. Among the various strategies and proposals have been attempts to turn the program from an entitlement into a fixed block grant to the states – that would give the states a fixed amount of money and let them spend it for poor recipients as they wished; an attempt to blend the federal match of the Medicaid and the SCHIP (State Children's Health Insurance Program) into a single fixed rate; restrictions on the ability of states to increase the federal match by limiting the use of provider taxes and other mechanisms that expand what states spend and that should get matched by the federal government; and by a variety of other approaches that would rein in federal Medicaid costs. In some of these approaches they have won the support of State Governors looking for more flexibility in spending and less restrictions on their programs, even though they are fully aware that over time the amount of money they would get would decrease.

The ACA Medicaid expansion would have provided a 100% federal match for the first three years (2014–2017), decreasing to a 90% match by 2019. Thus states would be able to establish the program at no cost to themselves for the first few years and have a continuing cost of only 10% going forward. While this might seem to be a great deal for the states, 26 states brought lawsuits challenging the Medicaid expansion in the courts.

Most policy analysts project that the ACA will lead to 32 million currently uninsured Americans receiving health insurance, almost half of those through an expansion of the Medicaid program to childless adults who would be covered up to 133% of the federal poverty level.[4] Essentially the ACA created a new mandatory coverage requirement for this population. As with other mandatory

4 138% of the federal poverty level after an adjustment for gross income. See "Determining income for adults applying for Medicaid and exchange coverage subsidies: how income measured with a prior tax return compares to current income at enrollment". Kaiser Family Foundation, March 2011.

https://doi.org/10.1017/S1744133112000400 Published online by Cambridge University Press

groups in the program, if a state chose not to cover the new group, it would lose all its Medicaid funding. The states that led the challenge on this argued that it was a coercive law and that states would be compelled to expand the Medicaid program to the new group because they could not afford to lose all their funding.

When the suit first came to public attention, it was not considered to be viable since the federal government has long had the authority to use funding to compel action, and therefore almost all the attention in the media and in policy circles revolved around the constitutionality of the individual mandate that requires people to purchase insurance. It was widely thought that if the court seriously considered this aspect of the suit, it was a sure sign that a radical revolution was occurring with federal power and authority being seriously compromised and that while this might be of interest to the conservatives on the court, it was an unlikely occurrence. It was thus something of a shock to find that the court upheld the individual mandate and the entire ACA, but on a 7–2 vote found that the Medicaid expansion was an overreach. The court ruled that the Medicaid expansion was an abuse of federal authority and its ruling turned the compulsory program into an option – meaning that a state could decide not to implement the expansion but keep the rest of its Medicaid program and the rest of its funding. The court argued that since Medicaid was such a large part of a state's budget they were compelled to go along with the expansion because they could not reasonably lose all the funding or afford to care for the population on their own. It did not take long before several Governors boasted that they would not expand their programs because the cost was too high.[5] Whether or not the Governors of these states carry through on their threats or attempt to leverage their participation for other benefits remains to be seen.

The Medicaid expansion portion of the ACA was expected to produce almost half of the newly insured population. The States that have threatened not to expand would have contributed a significant portion of the newly insured population. While it has been estimated that 3 million of the potential Medicaid population would be eligible for private coverage through the exchanges with subsidies, much depends on whether the states will carry out their threats not to expand, and perhaps even more depends on the outcome of the Presidential and congressional elections since Republicans have vowed to repeal the entire ACA if they have the votes.

It is certainly conceivable that the Governors are just blustering and that when push comes to shove they will not reject initially 100% federal funding and later on 90% federal funding to insure a large population. Governors will certainly be under pressure from constituents and special interests that may care less about

5 As of this writing, six states have publicly claimed that they will not expand – Florida, Texas, Louisiana, Wisconsin, South Carolina and Mississippi. Other states have said they will wait until after the Presidential election to make a decision. In any event, the expansion does not start until 2014, so there is some time for decisions to be made.

https://doi.org/10.1017/S1744133112000400 Published online by Cambridge University Press

the political principle and more about the consequences on their fiscal survival. Thus, it is likely that hospitals and their trade associations (but also doctors, pharmaceutical and medical supply companies and insurance companies) will be pressing very hard for states to expand their programs. It was the anticipated expansion of the insured population that led those interests to support the passage of the ACA in the first place. For hospitals an expansion will mean more revenue, less uncompensated care and perhaps most important, a way to deal with the ACA required reduction in Disproportionate Share Funding (DSH).[6] If their states do not expand, they will have less revenue to deal with a larger uninsured population. Similarly, doctors and insurance companies have been counting on additional revenue from these newly insured individuals.

It will also be difficult for the Governors to withstand the arguments from challengers that to make a grand political statement about keeping taxes low, they are using the tax dollars of residents of their state to pay for the Medicaid costs of people in other states, not an argument that will go over particularly well. Much more likely will be the attempt of the Governors to use the leverage of threatening not to expand to get special concessions out of the federal government that may be important to them. Among these may be approval of waivers that give the states more freedom to change the Medicaid program to the way they want, or to reduce the maintenance of effort required by the ACA,[7] or to get a higher matching rate. The federal government could just say no – if you don't want to expand you are not going to get any special consideration from us for your program, but much will depend on public sentiment and the composition of Congress and it is likely that states will also bring lawsuits challenging federal requirements back to the Supreme Court.

Federal Medicaid representatives have been implying that a state could expand the program in 2014 and later be free to drop the program when the federal matching grant begins to go down. They have also implied that a state could initially decide not to expand, but could change its mind at any point (as with any other optional benefit). Since the Medicaid expansion does not begin until 2014, there is a lot of time for posturing and threats and a lot of time for states to read the political landscape before making a commitment.

For whatever reason, the Supreme Court has heightened the tensions between a federally controlled Medicaid program and one in which the federal government merely finances what the states wish to do (Rosenbaum and Westmoreland, 2012). This further highlights the tensions between having national and state health care programs and provides little doubt that the United States will

6 DSH is a program that gives hospitals having large numbers of Medicaid and uninsured patients extra money to help them afford to care for these patients. The ACA begins to reduce DSH funding under the argument that with expanded Medicaid and private insurance, there are fewer uninsured and therefore less need for the money.

7 The Maintenance of Effort Requirement of the ACA does not allow states to cover fewer people than they are currently covering.

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have a significant uninsured population for a long time to come. Before the ruling, it was thought that the 50 million Americans who lack health insurance would be reduced to around 24 million by 2020, of whom a third would be undocumented residents. The ruling further politicizes health policy at the expense of coverage and establishes the states as the actors most responsible with dealing with health insurance decisions. It will thus take a major change in political beliefs across the country for there to be a consistent approach to health policy in the coming years in the United States. There is no doubt that the Supreme Court opened up a major can of worms for health policy going forward, one that will not be easy to resolve.

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https://doi.org/10.1017/S1744133112000400 Published online by Cambridge University Press