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Affordable Care Act Survives Supreme Court Test, But Medicaid Expansion Placed in Peril

By Adam Sonfield

After months of speculation, the U.S. Supreme Court surprised many if not most political observers by ruling on June 28 that almost all of the Patient Protection and Affordable Care Act (ACA) was constitutional, including the much-debated "individual mandate." The 5-4 decision, written by Chief Justice John Roberts and joined by the court's four left-leaning justices, is a critical victory for supporters of the health reform legislation and raises the stakes for the November 2012 elections.

If the law is fully implemented in 2014 as scheduled, tens of millions of Americans who otherwise would remain uninsured will instead be able to receive comprehensive health coverage through Medicaid or the private market. Significantly, all of those newly insured Americans will have strong coverage of reproductive health care—with the notable exception of abortion coverage, which is highly restricted under the ACA and already barred in many states under Medicaid and private insurance. The decision also means that a new requirement for most private health plans to cover contraceptive counseling and methods without additional costs to patients is still slated to go into effect on August 1, 2012 (affecting plans written or renewed after that date).

The Supreme Court added a major new piece of uncertainty to the law's implementation, however, by ruling that the federal government could not force states to accept one of the law's central provisions: its large-scale expansion to the Medicaid program. If states decide to opt out of that expansion, coverage for millions of the poorest Americans could be jeopardized. That threat adds to a long list of political, legal and technical challenges to realizing the full potential of the ACA, for reproductive health care and beyond.

Reform and Resistance

One of the driving factors behind President Obama's push for health reform legislation during his initial year in office was the high and rising number of Americans—roughly 50 million—without any form of health insurance.[1] Included in that number are about 13 million women aged 15–44, which amounts to 22% of reproductive-age women.[2]

The United States is highly unusual among developed nations, because it has no system for universal coverage, either through public programs or the private market. Rather, Americans rely on a patchwork system that includes health coverage sponsored by employers, unions or other groups; federal Medicare coverage for the elderly and disabled; the joint federal-state Medicaid program; and commercial insurance plans purchased by individuals and families without access to affordable group coverage. People who cannot afford private coverage and do not qualify for the public coverage programs can sometimes receive free or subsidized care from safety-net clinics or hospital emergency rooms, but often simply go without needed care.

Political conflicts over such issues as the rising cost of care and the appropriate role of the government in the health care arena derailed generations of attempts to establish universal coverage in the United States, most recently during the Clinton administration in the early 1990s. Taking their cue from the debates over those failed ef-

forts, President Obama and the Democratic leadership in Congress settled on a framework for health reform that relied primarily on the existing health insurance system and was modeled in large part on the Massachusetts health reform effort enacted in 2006. The ACA attempts to retain and shore up employer-sponsored insurance, while using expansions to Medicaid and federal subsidies in a reformed individual coverage market—in both cases, partnering with private health insurance companies—to add coverage for most of the currently uninsured population.

Notwithstanding its private-sector pedigree, the health reform legislation was nevertheless tarred by conservatives as a "government takeover" of the health care system, highlighting provisions such as the individual mandate, which requires most Americans to obtain health insurance or else pay a penalty. (Many progressives, meanwhile, objected to the legislation because it relied too heavily on the private sector, and unsuccessfully pushed for either a single-payer, government-run system, or at least a government-run "public option" to compete with the private plans.) No Republican in Congress voted for the final legislation, and conservative politicians have been unwavering in their political and legal attempts to undermine and ultimately repeal the law. The Supreme Court cases—brought by conservative officials in about half the states, along with the National Federation of Independent Business—were the culmination of one avenue of attack.

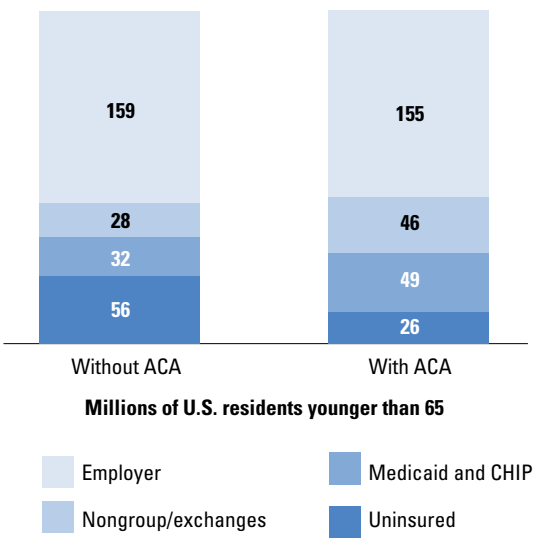
Expanded Coverage, Public and Private

The law relies on two major health coverage expansions to reduce the number of uninsured Americans, both of which are scheduled to be implemented in 2014. For the lowest-income Americans, the law works through Medicaid. Eligibility for Medicaid generally has been limited to certain categories of people, such as children and their parents, pregnant women and disabled adults; income eligibility ceilings vary widely from state to state, with the ceiling for parents averaging about two-thirds of the federal poverty level, and with childless adults generally excluded regardless of their income.[3] (The poverty level in 2012 is $19,090 for a family of three.[4]) Under the ACA, starting in 2014, those categories and variability were to be essentially eliminated: States were to be required to expand eligibility under Medicaid to all U.S. citizens (as well as immigrants after five years of legal residence) with a family income up to 138% of poverty. All of these newly eligible Medicaid recipients would be enrolled in managed care plans run by commercial insurers.

For somewhat higher-income Americans, the ACA instead works through the private insurance market. Individuals and small employers will be able to purchase private insurance through new state- or federally run marketplaces called exchanges. The law is designed to make that coverage more affordable than in the current marketplace, through a combination of market reforms, greater participation and federal subsidies for citizens and legal residents with family incomes below 400% of poverty. The Congressional Budget Office projected in March 2012 that these two expansions will result in 30 million fewer uninsured Americans in 2016 than would otherwise be the case (see chart);[5] however, it also projected that 26 million American residents will remain unin-

THE ACA'S POTENTIAL

Thirty million fewer Americans are expected to be uninsured in 2016 than would have been the case under prior law, because of expanded coverage through Medicaid and the new health insurance exchanges.



Notes: Exchange coverage would only exist under the "with ACA" scenario. The nongroup category also includes other types of coverage, such as Medicare. *Source:* reference 5.

sured that year, despite the ACA. Both projections are highly dependent on how well the federal and state governments set up systems to help people learn about and enroll in public and private plans (see "Implementing the Affordable Care Act: Enrollment Strategies and the U.S. Family Planning Effort," Fall 2011).

Medicaid and private insurance are both generally strong in their coverage of reproductive health services, and the ACA has several provisions that make this coverage even stronger. Medicaid law has for decades required states to cover family planning services and maternity care, and to do so without any out-of-pocket costs for patients. Coverage for STI testing and treatment, breast and cervical cancer screening, pregnancy tests and most other reproductive health services is also universal, and cost-sharing for these types of services is capped at a "nominal" amount. Abortion is the major exception: Since the late 1970s, the Hyde amendment has barred federal spending on abortion under Medicaid except in the most extreme circumstances, and the ACA extends this ban to those who will be newly eligible for Medicaid. Even so, 17 states use their own revenues to pay for all or most medically necessary abortions for Medicaid recipients.[6]

Private insurance also typically covers a broad range of reproductive health services. Some of that reflects the influence of prior federal and state law. For example, federal law since 1978 has required most employer-sponsored health coverage to include coverage for maternity care, and 28 states require private plans to cover the full range of prescription contraceptive methods, if they cover other prescription drugs.[7] Surveys from the last decade show that the vast majority of employer-sponsored plans cover these services along with most other reproductive health services,[8] but that some gaps remain. Coverage of maternity care is rare and expensive, for example, among plans sold directly to individuals and families.[9]

Several provisions of the ACA are designed to improve this coverage and make care more affordable. Starting in 2014, plans sold to individuals and small employers will be required to cover a package of "essential health benefits," specifically defined by Congress to include maternity care. And most private plans, as of September 2010, are required to cover a range of recommended preventive care services, without patient out-of-pocket costs. Additional preventive services for women have been added to that list, starting in August 2012. It will now include contraceptive methods and services, along with an annual well-woman preventive care visit, Pap tests, screening and counseling for HIV and other STIs, prenatal care services, the human papillomavirus vaccine, counseling and equipment to support breastfeeding, and screening and counseling for domestic violence. Again, abortion is the big exception: The federal government is barred from requiring abortion as an essential health benefit, and 20 states have laws banning private insurers from covering abortion through the exchanges and, in eight states, in plans outside of the exchanges as well.[10]

The bottom line is that for the tens of millions of American women and men who will gain insurance coverage under the ACA, along with far greater numbers who already have coverage, health insurance will mean better access to the reproductive health care that people need at different points in their lives. That includes the services they need to avoid, detect and treat STIs and reproductive cancers, to time and space their pregnancies, to achieve healthy births and to raise healthy children. And the ACA should help ensure that they can maintain high-quality coverage even when they change or lose their job, move to another city or state, get married or divorced, or struggle financially.

Uncertainty over Medicaid

The Supreme Court decision, however, seriously undermines the prospects that the ACA will meet its full potential, especially in its early years. Under the law, states were required to adhere to changes to the Medicaid program or else risk losing some or all of their federal Medicaid funds. Chief Justice Roberts—joined by six other members of the court—ruled that the federal government cannot use that financial lever to force states to participate in the new Medicaid expansion, effectively making the expansion a state option. Legal analysts will spend years debating

the potential fallout of this ruling on a wide range of other federal requirements on states, but the near-term implications for Medicaid could be considerable.

Because Congress, in drafting the ACA, had assumed that all states would be expanding their Medicaid programs, the Supreme Court's decision leaves a potentially sizable hole in the patchwork of programs it created to help ensure that Americans have access to affordable coverage. If a state opts out of the Medicaid expansion, most of its residents who would have been eligible for Medicaid will not be, but they also will not be eligible for the federal subsidies that the ACA will provide to higher-income Americans to help them purchase private insurance. The subsidies are set on a sliding scale for people between 100% and 400% of poverty. The only people below the poverty level who appear eligible as the statute is written are recent legal immigrants, who are barred from Medicaid for their first five years of residence. According to the Urban Institute, of the 15.1 million currently uninsured adults who would become newly eligible for Medicaid if all states participate in the expansion, 11.5 million—about three-quarters of the total—would be ineligible for subsidized coverage through the exchanges.[11]

It is not at all clear how many states will actually decide to opt out of the Medicaid expansion. The financial incentives to expand are considerable. The federal government will be paying for 100% of the cost for expansion enrollees for the first three years. That proportion will then gradually decrease to 90%, which is still far higher than the rates states receive for their current enrollees (from 50% to about 75%). Under past expansions to Medicaid—such as when Congress created its sister program, the Children's Health Insurance Program, in the late 1990s—every state ended up participating within a few years, despite considerably lower federal reimbursement than that promised by the ACA. Theoretically, at least, it should be difficult for states to pass up billions of federal dollars or to allow their residents' federal tax dollars to fund Medicaid expansions in other states, but not their own.

Moreover, states will feel pressure from many groups with a vested interest in seeing the Medicaid expansion go forward, including hospitals (which are worried about uncompensated care), insurance companies (which would profit from helping to run the expansion) and advocates for the poor. States could also object to the idea that some immigrants would have better access to affordable coverage than would citizens.

Conservative political pressure and perceived fiscal constraints push in the opposite direction, however. Indeed, within days of the decision, conservative policymakers in most of the 27 states that joined the lawsuits against the ACA[12] had declared themselves unwilling to join the Medicaid expansion or had expressed serious reservations. Louisiana Governor Bobby Jindal raised another possibility: that states would use the ruling as leverage to wring concessions out of the federal government.[13] In the most extreme scenario, a state might attempt to negotiate a "waiver" from federal law to turn Medicaid and the federal subsidies into a health care block grant for the state to shape free from federal constraints (see "Political Tug-of-War Over Medicaid Could Have Major Implications for Reproductive Health Care," Summer 2011). The Obama administration and congressional Democrats—if they are in power after the November 2012 elections—would likely resist any form of block grant and may be expected to pressure states to take up the Medicaid expansion as written. Although it does not appear politically likely at the moment, they could also attempt to mitigate the harm of the court's decision through a change in statute.

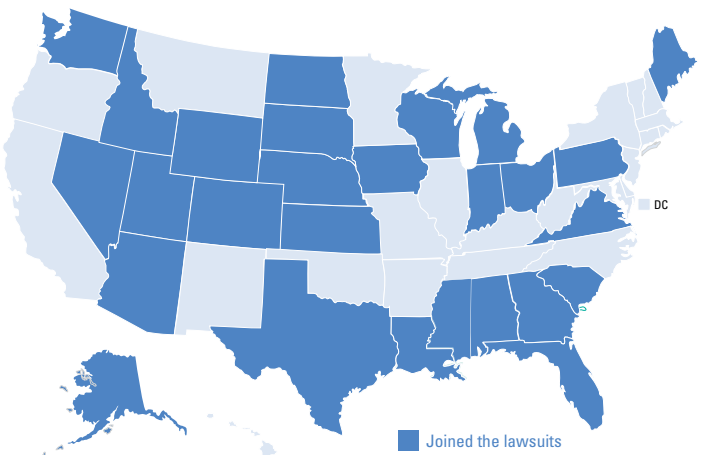
Ironically, the uncertainty over the Medicaid expansion could make another provision in the ACA even more valuable than expected: a provision that has made it easier for states to expand Medicaid specifically for family planning services to individuals otherwise ineligible for the program. Twenty-six states already have implemented this type of Medicaid family planning expansion, typically extending eligibility to women (and, in some states, men) with incomes up to around 200% of poverty—most often the same eligibility level the state uses for pregnant women. Eight of these states have expanded eli-

gibility using the new authority under the ACA, whereas the remainder have done so through the more complicated "waiver" process, starting as long ago as the mid-1990s.[14] These family planning expansion programs have not historically followed the typical red-blue pattern of American politics, and indeed, 14 of the 27 states that challenged the ACA in court—including almost every state in the conservative South—have an expansion in place (see map).

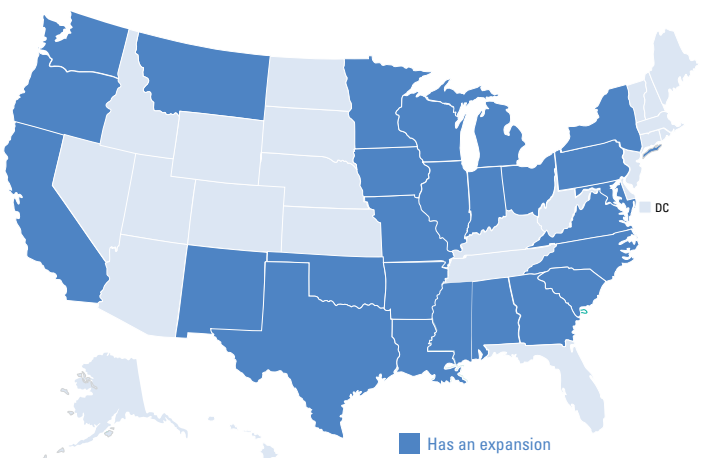
POLITICAL CONTRADICTION

Fourteen of the 27 states that challenged the health reform law in court have implemented a broad-based Medicaid family planning expansion.

Health Reform Lawsuits



Family Planning Expansions



Sources: references 12 and 14.

Further Implications and Challenges

Despite the uncertainty over the ACA's broad Medicaid expansion, the Supreme Court decision marks a significant victory for reproductive health. In addition to the expansions and improvements to Medicaid and private insurance coverage, the decision means that a series of other important provisions in the ACA that have implications for reproductive health will continue. Included are:

- a requirement that insurance plans allow individuals to remain on their parents' policy through age 26;
- a requirement for private plans to allow patients to access obstetric and gynecologic care without preauthorization or referral;
- prohibitions on charging women higher premiums than men and on excluding coverage for preexisting medical conditions;
- funding for the Personal Responsibility Education Program, which provides education to adolescents on both abstinence and contraception, along with such subjects as healthy relationships, parent-child communication and decision making;
- new funding for community health centers and school-based health centers, most of which provide family planning services and other basic reproductive health care to their clients;
- grant funding for states to support pregnant and parenting teens and women, connecting them to services such as prenatal care, housing, and baby food and clothes; and
- funding to support maternal, infant and early childhood home visiting programs, which are designed to improve prenatal, maternal and newborn health, including pregnancy outcomes, and to otherwise improve childhood outcomes.

Yet, additional legal, political and technical challenges loom large. The contraceptive coverage guarantee, notably, is being challenged in a series of separate lawsuits that will continue despite the Supreme Court ruling. Those lawsuits—brought by a range of Catholic and evangelical Protestant groups—contend that the requirement infringes on the religious freedom of employers that arrange for health insurance for their employees,

by forcing the employers to pay for, facilitate and effectively endorse a health service that they view as sinful and sometimes tantamount to abortion. The Obama administration has attempted to alleviate these concerns through an exemption for houses of worship and an accommodation for other religiously affiliated employers, such as hospitals and universities; that accommodation would rely on third-party insurers and administrators to pay for, arrange and communicate to employees about the contraceptive coverage. So far, the U.S. Conference of Catholic Bishops and other opponents of the requirement have rejected these compromises and are insisting on the requirement's repeal, or else a sweeping exemption that would allow any entity (or even an individual business owner) to reject coverage for their employees of any service to which the employer has a religious or moral exemption.

Conservatives in Congress and the states, moreover, continue to trumpet their opposition to what they refer to mockingly as "Obamacare" (although it appears that the administration's allies and even the administration itself are now embracing the term). The House Republican leadership has promised additional votes to repeal the law in its entirety and to attack the contraceptive coverage requirement and other provisions they deem objectionable. Republican presidential nominee Mitt Romney and other conservatives running for office in November are certain to make the ACA a centerpiece of their campaigns and to attempt to repeal the law, if elected.

Meanwhile, federal and state officials, along with the health care industry, are scrambling to set up new agencies and systems, and otherwise prepare for the immense changes to the health care marketplace slated for 2014. In many states, particularly those that joined the lawsuits against the ACA, preparations for setting up the health insurance exchanges are far behind schedule, and the federal government may have to step in to ensure that an exchange is in place on time in every state. Dozens of additional federal regulations are still in draft form, leaving states, insurers and health care providers uncertain about countless fine details of how the law will be interpreted and implemented. Agencies must make considerable new investments in outreach campaigns, enrollment systems, electronic information exchanges, quality assurance efforts and numerous other measures to improve coverage and care, and ensure financial accountability. All in all, the Supreme Court's decision was just one milestone—although a singularly critical one—along a long road to successful health reform.

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