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The Supreme Court and the ACA's Medicaid's Expansion

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The United States Supreme Court has decided that the Medicaid Expansion provision of the Patient Protection and Affordable Care Act (ACA) is a "gun to the head" of the states, coercing states to expand Medicaid to additional low-income people by threatening them with the loss of existing Medicaid funding. Without question, the decision announced in *National Federal of Independent Business v. Sebelius* (*NFIB*) is one of the most significant of the last 70 years. It could affect Congress's ability to enact legislation under its Spending Clause authority to tax and spend for the general welfare. It will certainly affect how some states approach the ACA's mandate to expand Medicaid coverage by January 2014 to uninsured individuals with incomes below roughly 133% of the federal poverty level—for the most part, non-elderly adults who are not disabled.

This issue of the *Health Advocate* provides an overview of the Medicaid decision, responds to some frequently asked questions about the decision, and suggests reasons why states should implement the Medicaid Expansion.

Background to NFIB

Nothing about *NFIB* has been routine. From March 26-28, 2012, the Supreme Court heard six hours of arguments in the case—a modern day record. Over 140 amicus (friend of the court) briefs were submitted—an all-time record.

Among the attacks lodged against the ACA was a claim by 26 elected state officials that the Medicaid Expansion—which will not occur until January 2014—was unduly coercive. Legally framed, the question was:

> Did Congress have the power under the Constitution's Spending Clause to authorize termination of all federal Medicaid funding to a state that refused to implement the ACA requirement to expand Medicaid coverage to all individuals under 133% of the federal poverty level?

In a surprise, the Supreme Court agreed to decide the state officials' claim. No court—let alone the Supreme Court—had ever held a Spending Clause enactment to be unduly coercive. Thus, it was another, major surprise when the Court sided with the state officials by a vote of 7-2 (with only Justices Ginsburg and Sotomayor dissenting). Of equal interest is how a plurality of the Court, consisting of the Chief Justice and Justices Breyer and Kagan, crafted a remedy for the violation that gained the support of Justices Ginsburg and Sotomayor to form a 5-4 majority.

Key Resources

- Check out NHeLP's new Medicaid Expansion Toolbox for the latest analysis of the Supreme Court's decision, available here.
- NHeLP Factsheet: The Supreme Court's ACA Decision & Its Implications for Medicaid, available here.
- NHeLP Factsheet: 50 Reasons Medicaid Expansion is Good for Your State, available here.
- NHeLP Factsheet: 10 Advocacy Steps to Support a Medicaid Expansion in Your State, available here.
- NHeLP Q&A: Disproportionate Share Hospital Payments and the Medicaid Expansion, available here.

Coming in September's Health Advocate:

Managed Care

Summary of the Medicaid Decision

The Spending Clause of the Constitution, Art. I, § 8, cl.1, empowers Congress to tax and spend to provide for the "general welfare of the United States." Congress has used this authority to address a number of issues on which it cannot directly legislate by offering federal funds to States in return for their agreement to abide by the standards set by the federal government as a condition of receiving the funding. Over the years, States have filed suits arguing that the conditions are unduly coercive and therefore invalid. One of the most important cases on this issue was *South Dakota v. Dole*, a 1987 case in which the State argued that a Congressional requirement that states raise their drinking age to 21 or risk the loss of 5% of their federal highway funding allotment crossed the line into impermissible coercion. The Court in *Dole* rejected this argument but noted in passing that "[o]ur decisions have recognized that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which pressure turns into compulsion." *See South Dakota v. Dole*, 483 U.S. 203 (1987).

In *NFIB,* the Court accepted the argument that the ACA's Medicaid Expansion was unduly coercive. The ACA inserted the Expansion into the existing Medicaid statute, which includes a long-standing provision authorizing the Secretary of Health and Human Services (HHS) to terminate all federal Medicaid funding to a state that does not comply with a mandatory federal requirement, 42 U.S.C. § 1396c. Thus, the state officials argued, if they did not implement the Expansion, they would lose all of their Medicaid funds and, due to their dependence on the funds, had no choice but to participate.

Accepting this argument at face value without any evidence that any states would actually be coerced, the controlling *NFIB* opinion—a plurality opinion signed by only three justices—rests on three premises. First, the Medicaid Expansion "accomplishes a shift in kind, not merely degree. The original program was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children." Previous Medicaid amendments and expansions, such as those in the 1980s and 90s, concerned only these populations. By contrast, the ACA's Medicaid expansion mandated inclusion of an entirely new group, an action that the Court decided "transformed" Medicaid from a program serving designated population groups" to "a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the federal poverty level." Accordingly, the ACA expansion made Medicaid "no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage."

Second, the plurality found that states were being treated unfairly because they had inadequate notice that the new expansion program would be a part of the Medicaid program when they agreed to participate in it. Previous Supreme Court cases (that, notably, did not address coercion) have noted that Spending Clause programs are similar to contracts. Thus, Congress must establish clear notice of Spending Clause requirements so that States will know what they are agreeing to at the time that they agree to participate. According to the plurality opinion, when States first decided to participate in Medicaid, they did not foresee a requirement to include everyone below a certain percentage of poverty.

Finally, likening the situation to "a gun to the head," the plurality found that Congress was forcing the States to accept the unanticipated new program by threatening them with the loss of all federal funding for the old one. "The threatened loss of over 10% of a State's overall budget … is economic dragooning that leaves the States no real option but to acquiesce in the Medicaid expansion." Notably, the provision that allows the Secretary of HHS to deny all or part of a non-compliant State's federal Medicaid funding if it violates the terms of the Medicaid program has never been used to terminate the entirely of a State's funding. *See NFIB v. Sebelius*, 132 S. Ct. 2566, 2604-06 (2012).

The next question facing the Court was how to craft a remedy. A 5-member majority agreed to Chief Justice Roberts' deft conclusion: The constitutional violation is "fully remed[ied]" by prohibiting the Secretary of HHS from terminating existing federal Medicaid funding of a State that does not implement the expansion. This holding is intended to be narrowly construed:

> 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.

Thus, the decision remedies the undue coercion by curbing the power of the federal government to enforce the Medicaid expansion but maintains the ACA and the Medicaid Act in all other respects. *See NFIB*, 132 S. Ct. at 2607.

As a result, States are now considering whether to comply with the Medicaid Expansion. Nevertheless, it is important to keep in mind that the result here is far less destructive than it could have been—given that the 4 dissenting justices would have found the Medicaid Expansion unconstitutional and struck down the ACA in its entirety. To put it another way, the Medicaid Expansion and the entire ACA were saved by the vote of a single Supreme Court justice.

NFIB's Implications for Medicaid Implementation

Not surprisingly, *NFIB* is raising questions. Based upon our reading of *NFIB* and understanding of text of the ACA, NHeLP recently issued a series of Q&As on implications of the ruling. Among them:

Does NFIB relate to all of the Medicaid provisions in the ACA?

No. As limited by Chief Justice Roberts, *NFIB* only addresses the Medicaid Expansion provisions. Thus, the other newly added Medicaid provisions continue in full force and effect in all states, including requirements for coverage of young adults leaving the foster care system, temporary Medicare-Medicaid rate parity for primary care providers, and options for expanding coverage of community-based services and supports for people with disabilities and the elderly.

Does NFIB affect the enhanced federal funding that the ACA provides to states when they implement the Medicaid Expansion?

No. The Medicaid Act's enhanced funding provisions are not affected by NFIB. When states implement the Medicaid Expansion as set forth at §1396a(a)(10)(A)(i)(VIII), they will receive generous federal funding: 100% federal funding for three full years, to be phased down to 90% by 2020. This compares with a national average of 57% for most Medicaid services. (The federal share of funding varies in different states.)

If a state does not take up the Medicaid Expansion, will coverage for people with incomes below 133% of poverty be affected?

Yes. Beginning January 2014, people with limited incomes will be eligible for tax subsidies to help them purchase health insurance. However, individuals with incomes below 100% of the FPL are generally not eligible for these subsidies.

Source: NHeLP Q&A #1 (July 2012)
Available at: NHeLP Medicaid Expansion Toolbox

Reasons Why States Should Implement the Medicaid Expansion

Unfortunately, the Medicaid Expansion has become a victim of politics. Elected officials are weighing not only how the Expansion will operate in their state but also how their position will affect them politically. There are a number of reasons states should implement the Medicaid Expansion, including:

- ✓ Federal funding for the Medicaid Expansion population is extraordinarily generous: 100% for three full years beginning in 2014 and 90% thereafter. This compares to, on average, 57% federal funding.
- ✓ The Medicaid Expansion will help stop the deterioration in health access that nonelderly adults—many of them working adults—have been experiencing over the last decade. States will experience significant reductions in the number of uninsured adult residents, particularly in southern states, where, on average, a 50% reduction will occur.
- ✓ Medicaid Expansion will allow access to health services for Veterans who live in the state, covering one half of the 1.3 million currently uninsured Vets.
- ✓ Medicaid Expansion will improve financial security. Tracking of Oregon's Medicaid Expansion to uninsured adults found the coverage reduces by 40% the probability that people report having to borrow money or skip payment on other bills because of Medicaid expenses. It decreases by 25% the probability that they will have unpaid medical bills sent to a collection agency.
- ✓ Hospitals are vital to communities' health and work force. State and local governments help hospitals offset the cost of care they provide to uninsured patients who can't pay for medical care—paying about $10.5 billion, or 18.5%, of the cost of uncompensated care. The ACA will roughly halve state spending on uncompensated care, thus freeing up this funding for other purposes.
- ✓ Medicaid Expansion will reduce state spending on mental health services for uninsured patients, thus freeing up this funding for other purposes. State governments covered 42% of the cost of state mental health expenditures in 2009, totaling $16.3 billion. This includes services provided by state mental hospitals, hospital emergency rooms and community health clinics.
- ✓ Almost everyone pays federal taxes and federal dollars will pay for the Medicaid Expansion. Taxpayers residing in states that do not implement the Expansion will be paying out dollars to states that do expand.
- ✓ The Medicaid Expansion means jobs. The Expansion would bring over 7,500 jobs to Tennessee in 2014 alone. Following the increase in the federal Medicaid matching rate in the American Recovery and Reinvestment Act, one estimate from Illinois found the Medicaid program supported as many as 385,742 jobs during FY 2009. Refusing to expand is a job killer.
- ✓ Read all 50 reasons states should implement the Medicaid expansion here.

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

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